PRINTED: 03/12/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020)
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLÉ	TION
F 000	INITIAL COMMENTS		F 0	00		
F 550 SS=D	survey was conducter Corrections are requifollowing 42 CFR Par Care requirements. Finvestigated during the Code survey/report with Code survey/report	ris survey. The Life Safety rill follow. 5 certified bed facility was survey. The survey sample ent resident reviews and 5 s. cise of Rights (2)(b)(1)(2) Rights. Ight to a dignified existence, and communication with and doservices inside and cluding those specified in ty must treat each resident ity and care for each and in an environment that the or enhancement of his or organizing each resident's lity must protect and	F 5:	50	2/17/20	
	provision of services residents regardless					
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE	(X6) DATE	

02/06/2020 **Electronically Signed**

Facility ID: VA0270

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495227	B. WING	·····	01/16/2020
WESTPORT REHABILITATION AND NURSING CENTER 7300 FORES			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 550	Continued From pag	ge 1	F 5	50	
	rights as a resident or resident of the Ur §483.10(b)(1) The faresident can exercise interference, coerciofrom the facility. §483.10(b)(2) The refree of interference, reprisal from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility and to be sup exercise of his or he subpart. This REQUIREMENT by: Based on observation staff interview, it was failed to promote digincontinence care for survey sample, Resident # 64 was a diagnoses that including the findings included the resident # 64 was a diagnoses that including swallowing difficultied resident # 64's mosset), an admission a (assessment reference)	eright to exercise his or her of the facility and as a citizen nited States. acility must ensure that the e his or her rights without on, discrimination, or reprisal esident has the right to be coercion, discrimination, and ility in exercising his or her ported by the facility in the er rights as required under this er rights as required under this on, resident interview and as determined that facility staff guity by providing timely or one of 60 residents in the idents # 64. Endmitted to the facility with ded but were not limited to: In [1], muscle weakness and ess. St recent MDS (minimum data assessment with an ARD noce date) of 12/02/19, coded		F550-D Resident Rights/Exercise of Rights 1) Corrective Action for those resident to be affected by the alleged deficient practice. Resident #64 received incontinence at 3:30pm by the shift supervisor. Son assessment completed at that time there was no evidence of skin break or any skin issues. 2) Corrective Actions taken for resident practice. All Residents in the facility have the potential to be affected. 3) Systemic Changes put into place.	dents care kin and kdown sidents jed ne cted.
	interview for mental - 15, 12 - being mod	oring a 12 on the brief status (BIMS) of a score of 0 lerately impaired of cognition isions. Resident # 64 was		ensure the alleged deficient practice not recur. In-service for the Licensed Nurses was completed by the Director of Nursin	vill be

Facility ID: VA0270

		` IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/16/2020	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550	staff member for acti H "Bladder and Bown as being frequently in bladder. On 01/14/2020 at 3:' with Resident # 64, s [certified nursing ass to be changed at 2:0 "I rang my call bell at and I told her I need she would be back. asked about being so she had a bowel mon asked how it made h extended period of ti makes me feel like I' a little mistreatment.' The comprehensive dated 12/05/2019 do incontinence related generalized weaknes issues. Date Initiated "Interventions", it do assistance with toilet care as needed. Dat On 01/15/20 at 7:39 conducted with CNA staff follows for respon for a resident who re CNA # 4 stated, "I ch When asked to desc when they are provice at the same time, CN know I am busy and	extensive assistance of one vities of daily living. Section cell Resident # 64 was coded incontinent of bowel and 10 p.m., during an interview stated that she let CNA istant] # 4 know she needed 0 p.m. Resident # 64 Stated, and she [CNA # 4] came in to be cleaned and she said No one has come." When boiled, Resident # 64 stated wement and was wet. When er feel to be left soiled for an ame, Resident # 64 stated, "It am worthless. I feel like this is care plan for Resident # 64 cumented, "Need: Urinary to decreased mobility as, dementia, multiple health d: 12/05/2019." Under	F 55	designee on promoting dignity providing timely incontinence of neglect and resident rights for the state of t	are, the staff. or residents y alleged will conduct continence then sure information he quality aprovement		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		l c	1/16/2020	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 550	longer period than ar would let them know nurse know." When a resident was left so CNA # 4 stated, "Skir could contribute to a When asked if she w 64 on 01/14/2020 dup.m. shift, CNA # 4 stated, "I recalled the she informed me at a p.m." When asked if be left soiled for forty CNA # 4 stated no. Gide tracked." CNA # dignified to leave Resperiod of time. CNA # The facility policy, "R documented in part," respect and dignity The facility's policy "Resident Dignity" documented in part, respect and dignity a resident rights and tracked. The facility spolicy are sident in a manner maintains or enhance recognizing each res Compliance Guidelin involved in providing and maintain resident	re for another resident for a sticipated, CNA # 4 stated, "I I'm still tied up or let my asked what would happen if iled for a long period of time, a could break down or it UTI [urinary tract infection]." as assigned to Resident # ring the 7:00 a.m. to 3:00 rated, yes. When asked if at # 64 asked for 2:00 p.m. that day, CNA # 4 resident telling me. I think about 2:30 p.m., or 2:45 Resident # 64 soiled should five minutes to an hour, CNA # 4 further stated, "I got that # 4 stated no. The sident for that the stated is a soiled for that the stated in part, "Policy: It is collist to protect and promote that the serion of the swell as care for each and in an environment that the sresident's quality of life by	F 5	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING	B. WING		01/1	16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD B		(X5) COMPLETION DATE
F 578 SS=E	[administrative staff r administrator, ASM # made aware of the fill No further information. References: [1] An infection in the information was obtain https://www.nlm.nih.go00521.htm. Request/Refuse/Dsc CFR(s): 483.10(c)(6) The rigdiscontinue treatment to participate in experimental formulate an advance §483.10(c)(8) Nothin construed as the right the provision of medical results.	proximately 5:40 p.m. ASM member] # 1, the # 2, director of nursing, were ndings. In was provided prior to exit. In urinary tract. This ined from the website: gov/medlineplus/ency/article/ Intrue Trmnt;FormIte Adv Dir (8)(g)(12)(i)-(v) In the request, refuse, and/or it, to participate in or refuse rimental research, and to be directive. In this paragraph should be it of the resident to receive cal treatment or medical		550 DEFICIEN	NCY)		2/17/20
	inappropriate. §483.10(g)(12) The frequirements specific subpart I (Advance Direction of the subpart I) (i) These requirement inform and provide wresidents concerning medical or surgical tresident's option, form (ii) This includes a write facility's policies to in and applicable State	ts include provisions to ritten information to all adult the right to accept or refuse reatment and, at the mulate an advance directive. ritten description of the applement advance directives					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 578	legally responsible requirements of thi (iv) If an adult indivitime of admission a information or article has executed an amay give advance individual's resident with State Law. (v) The facility is not provide this information or she is able to refollow-up procedut the information to trappropriate time. This REQUIREME by: Based on staff intered and clinical record the facility staff failure facility staff failure facility staff failure accurately, docume status on the admit Acknowledgement forms were maintal Resident #135, #6 staff failed to accur Directive Acknowled accurately determines the status on admission #22, Resident #44, #57, and the facility Resident #78's Res	ois information but are still for ensuring that the	F 5	F578 Request/Refuse/Discon Treatment; Formulate an Adva Directive 1) Corrective Action for those found to be affected by the alle deficient practice. Resident #5 have been discharged. Reside #61, #3, #78, #149, #22, #73, #80, #57, #136, #40 and #45 a will be provided information on an Advanced Directives. 2) Corrective Actions taken f with potential to be affected by deficient practice. Residents w facility and those admitted to fathe potential to be affected. The service staff or designee will caudit on current residents to reresidents have an Advance Directiver or scanned in PCC.	e residents eged 33 and # 81 ent #135, #44, #47, and/or RP or formulating for residents / alleged within the facility have the social complete an eview if		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495227			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 01/16/2020	
		B. WING		0			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				7300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	ND NURSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 578	Continued From pag	ne 6	F 57	78			
	clinical record.						
	The findings include	:		Systemic Changes put ensure the alleged deficient not recur. In-service will be the Director of Nursing or definition.	t practice does completed by		
	12/23/19; with the di type 1 diabetes, orth stage renal disease, osteoporosis, pressu hyperparathyroidism Admission MDS (Mir with an ARD (Assest 12/29/19, coded the intact in ability to match the facility policy, Adocumented in part, admission of a reside Services Director or information to the reright to make decision cluding the right to surgical treatment, a	are ulcers, hypothermia, I, and convulsions. The Inimum Data Set) assessment Isment Reference Date) of Iresident as being cognitively It deally life decisions. In devanced Directives In Prior to or upon It our facility, the Social It designee will provide written I It sident concerning his/her It is on the right to formulate		licensed nurses, admission service staff on reviewing, r collecting of appropriate Ad Directive information for Re admission and during care Ensuring copies of Advance are placed in Resident char necessary. 4) Corrective Actions take with potential to be affected deficient practice. Director of designee will complete aud weeks then monthly x3 on the ensure that Advanced Director reviewed and recorded appropriate and admission and during care Ensuring copies of Advance are placed in Resident char	s and social recording and vanced sident s at plan meetings. ed Directives as en for residents ed by alleged of Nursing or its weekly x4 Residents to ctives are being ropriately on plans. ed Directives at as		
	director or designee and/or his/her family existence of any writ Information about whexecuted an advance displayed prominent the resident indicate established advance will offer assistance directives. The resid accept or decline the be contingent on eith	ent, the Social Services will inquire of the resident, members, about the ten advance directives. 4. nether or not the resident has		necessary. The audits will be the quality assurance and primprovement process for trained revisions as needed. 5) Date of compliance- 2/	performance acking/trending		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			01/16/2020
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	decline15. The lireview annually wit advance directives are still the wishes will be made during process and record assessment instrum. A review of the "Ad Acknowledgement" revealed the following PLEASE READ TH STATEMENTS. Plastatement: (Note, the assumed that the form document of the process of the p	lent's decisions to accept of interdisciplinary Team will in the resident his or her to ensure that such directives of the resident. Such reviews in the annual assessment ed on the resident ment (MDS). I wance Directive form for Resident #135 ing documentation: E FOLLOWING FOUR acce your initials after each there were 5 statements, not 4 ented there were.) I wanted there were.) I wanted there were. (initialed). In the resident representative interest in the resident representative interest in the resident representative did not initial wit I am not required to have an in order to receive medical ealth care facility. It is a company to the resident representative did not initial ealth care facility. It is a company to the resident in the	F 5	78		
	Directive that I have	at the terms of any Advance executed will be followed by lity and my caregivers to the law (initialed). The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	495227	B. WING		01/16/2020	
OVIDER OR SUPPLIER T REHABILITATION AI	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION	
resident and/or the rinitial this line. 5. It was recommented from my physician at this decision and/or the resident rinitial line. PLEASE CHECK OF STATEMENTS: () I HAVE executed The resident and/or initialed this line. () I HAVE NOT of Directive I would like assistant Directive () Yes, was checked and the this form on 1/14/20. Review of the clinicate form was maintained form was maintained. Further review of the reveal any evidence Advance Directives. An interview was constaff Member - the state of the s	resident representative did not inded that I also seek advice and attorney prior to making (initialed). The resident representative did not initial on the control of the c	F 578			
	CORRECTION DIVIDER OR SUPPLIER FREHABILITATION AI SUMMARY S (EACH DEFICIEN REGULATORY OF PREGULATORY OF PREG	A95227 DVIDER OR SUPPLIER F REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 resident and/or the resident representative did not initial this line. 5. It was recommended that I also seek advice from my physician and attorney prior to making this decision (initialed). The resident and/or the resident representative did not initial this line. PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: () I HAVE executed an Advance Directive. The resident and/or the resident representative initialed this line. () I HAVE NOT executed an Advance Directive I would like assistance in obtaining Advance Directive I would like assistance in obtaining Advance Directive I would like assistance in obtaining Advance Directive () Yes, () No. the box for "No" was checked and the resident signed and dated this form on 1/14/20. Review of the clinical record failed to reveal this form was maintained on the clinical record. Further review of the clinical record failed to reveal any evidence that the resident had	DOUDER OR SUPPLIER FREHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 resident and/or the resident representative did not initial this line. 5. It was recommended that I also seek advice from my physician and attorney prior to making this decision. (initialed). The resident and/or the resident representative did not initial this line. PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: () I HAVE executed an Advance Directive. The resident and/or the resident representative initialed this line. () I HAVE NOT executed an Advance Directive I would like assistance in obtaining Advance Directive () Yes, () No. the box for "No" was checked and the resident signed and dated this form on 1/14/20. Review of the clinical record failed to reveal this form was maintained on the clinical record. Further review of the clinical record failed to reveal any evidence that the resident had Advance Directives. An interview was conducted with OSM #4 (Other Staff Member - the social worker) on 1/15/2020 at 12:51 p.m. When asked who obtains the acknowledgement of the Advanced Directive, OSM #4 stated she had spoken to the admissions staff member that there was a misconception that the DNR (do not resuscitate)	DORRECTION DENTIFICATION NUMBER: A BUILDING	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		٥	1/16/2020
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 578	"Advanced Directive reviewed with OSM before today, it was completion of a DNF Advanced Directive found out today that many of the forms (Acknowledgment fo residents may not homes ('Advanced Directive fon the chart were for the complete one of the complete one day the complete one	mber, on 1/15/2020. The Acknowledgement" was #1. OSM #1 stated that her understanding that the R was the same as an She stated that she just it wasn't the same thing, so Advanced Directive rms) are incorrect and the ave an Advanced Directive. PM, OSM #4 stated that the rective' forms) that were not und in the business office. Prehensive care planted 12/24/19 for "Advanced intervention documented, intervention documented, intervention documented, S, "Full Code." PM, ASM #1 (Administrative dministrator), ASM #2 (the ASM #3 (the corporate (the Medical Director) were	F 5	78		
	1/1/20 with the diag sinus syndrome, bra insomnia, aphasia, l dementia, diabetes, chronic obstructive post-traumatic stres lymphoma, breast c	s admitted to the facility on noses of but not limited to sick adycardia, pacemaker, nigh blood pressure, vascular chronic kidney disease, bulmonary disease, s disorder, Non-Hodgkin's ancer, and stroke. The DS (Minimum Data Set) with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/	16/2020	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			7300 FC	TADDRESS, CITY, STATE, ZIP CODE DREST AVE IOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 578	an ARD (Assessment coded the resident as ability to make daily line. A review of the "Adva Acknowledgement" for documented the follow PLEASE READ THE STATEMENTS. Place statement: (Note, the as the form documented the resident representative in the resident representative initialed and the facility. (initialed representative initialed the health care facility extent permitted by la resident representative to the was recommended. It was recommended to the facility of the second that the promitted by la resident representative.	Reference Date) of 1/7/20 being severely impaired in fe decisions. Ince Directive form for Resident #61 wing: FOLLOWING FOUR e your initials after each fre were 5 statements, not 4 ted there were.) written materials on and about my right to accept forments(initialed). Intative initialed this line. and of my rights to formulate(initialed). The resident d this line. and not required to have an order to receive medical alth care being in the company of the terms of any Advance for executed will be followed by and my caregivers to the former initialed this line. The resident d this line. The decisions.	F	578				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
	495227 B. WING			01/16/2020			
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZII 7300 FOREST AVE RICHMOND, VA 23226	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 578	STATEMENTS: () I HAVE executed This box was checked () I HAVE NOT exported to Directive I would like assistance Directive () Yes, (was checked and the signed and dated this Review of the clinical form was maintained Further review of the reveal any evidence Advance Directives. An interview was constaff Member - the second and the signed and dated this Review of the reveal any evidence Advance Directives. An interview was constaff Member - the second admissions staff members and the same as the reviewed with OSM #4 stated she in the same as the reviewed with OSM #4 stated Directive reviewed with OSM #4 before today, it was the completion of a DNR Advanced Directive. Tound out today that it many of the forms (A Acknowledgment forms)	ed an Advance Directive - d for this resident. Executed an Advance The in obtaining The in obta	F	578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	Continued From page	e 12	F 5	778			
	ones ('Advanced Dire on the chart were four A review of the complete documented one date Directive." The only it dated 1/13/20, was, " On 1/15/20 at 5:41 PI Staff Member, the Ad Director of Nursing), A	ed 1/10/20 for "Advanced ntervention documented, Full Code." M, ASM #1 (Administrative ministrator), ASM #2 (the ASM #3 (the corporate the Medical Director) were ndings. No further					
	facility on 12/30/19 w limited to chronic kidr disorder, neuromuscu bladder, pressure ulc hypothyroidism, Park diabetes, hereditary s stenosis, anxiety, depon palliative care. The (Minimum Data Set) w Reference Date) of 1/2	ular dysfunction of the er, dysphagia, inson's disease, type 2 spastic paraplegia, spinal pression, obesity, and was be Significant Change MDS with an ARD (Assessment 4/5/20 coded the resident as paired in ability to make daily since Directive prm for Resident #3 wing:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/	16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	·	73	TREET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	STATEMENTS. Plastatement: (Note, that the form document of the statement: (Note, that is the form document of the resident representative in treatments at this health care facility. (initially representative in treatments at this health care facility the health care facility extent permitted by resident representative in treatments at the health care facility extent permitted by resident representative in the health care facility representative in the health care facility extent permitted by resident representative in this decision. The presentative in the health care facility representative in the health care facility representative in the health care facility representative in this decision. The health care facility of	nere were 5 statements, not 4 ented there were.) In written materials on and about my right to accept eatments(initialed). In written materials on and about my right to accept eatments(initialed). In written materials on accept eatments(initialed). In written materials on accept eatments(initialed). In written materials on accept eatments(initialed). The resident led this line. It I am not required to have an accept eath care eath. The resident led this line. If the terms of any Advance executed will be followed by ity and my caregivers to the law(initialed). The tive initialed this line. Indeed that I also seek advice and attorney prior to making (initialed). The resident led this line. INE OF THE FOLLOWING ted an Advance Directive.	F	578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 578	Continued From pa was checked and the signed and dated the	ne resident representative	F 578			
	Review of the clinic	al record failed to reveal this ed on the clinical record.				
		e clinical record failed to e that the resident had				
	ones ('Advanced Di	PM, OSM #4 stated that the irective' forms) that were not bund in the business office.				
	documented one da Directive." The inte "Discuss Advance I or Legal Represent	aprehensive care plan ated 5/17/18 for "Advanced erventions documented were, Directives with Patient, Family ative as needed" dated ode" dated 5/17/18.				
	Staff Member, the A Director of Nursing) nurse), and ASM #4 made aware of the	PM, ASM #1 (Administrative Administrator), ASM #2 (the b), ASM #3 (the corporate 4 (the Medical Director) were findings. No further ovided by the end of the				
	10/27/19; diagnose to right fibula fractu hemiplegia, chronic disease, seizures, a wasting, contracture dysfunction, high bl	as admitted to the facility on s included but are not limited re, dysphagia, diabetes, s obstructive pulmonary atrial fibrillation, muscle e, neuromuscular bladder ood pressure, dysphagia and sion MDS (Minimum Data Set)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/	16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From pag	ge 15	F:	578			
	11/3/19 coded the re	sment Reference Date) of esident as severely cognitively make daily life decisions.					
		t #78's "Advance Directive form documented the					
	STATEMENTS. Pla	E FOLLOWING FOUR ce your initials after each nere were 5 statements, not 4 nted there were.)					
	Advance Directives or refuse medical tre	n written materials on and about my right to accept eatments(initialed). resident representative did					
	Advance Directives.	med of my rights to formulate(initialed). The resident esentative did not initial this					
	Advance Directive in treatments at this he facility(initiale resident represental 4. I understand that Directive that I have the health care facil extent permitted by	I am not required to have an order to receive medical ealth care ed). The resident and/or tive did not initial this line. It the terms of any Advance executed will be followed by ity and my caregivers to the law(initialed). The dent representative did not					
	from my physician a	nded that I also seek advice and attorney prior to making (initialed). The resident and/or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			01/	16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER	·	STREET ADDRESS, CIT 7300 FOREST AVE RICHMOND, VA 23			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	PLEASE CHECK ON STATEMENTS: () I HAVE execut () I HAVE NOT e. Directive - This box v. I would like assistand Directive () Yes, was checked and the signed and dated this. Review of the clinica form was maintained. On 1/16/20 at 2:19 Pones ('Advanced Directive The chart were for th	we did not initial this line. WE OF THE FOLLOWING ed an Advance Directive executed an Advance was checked for this resident. The in obtaining Advance () No. The box for "No" exercident representative is form on 10/27/19. If record failed to reveal this is on the clinical record. The infinity of the infinity	F	578			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE CORRECTION OF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 578	hypothyroidism, hig syndrome (1), atrial transplant. The 5-d with an ARD (Assest coded the resident ability to make daily A review of the clinic "Advance Directive Resident #149. Thi following: PLEASE READ THI STATEMENTS. Plastatement: (Note, that is the form docume 1. I have been give Advance Directives or refuse medical transplant to the resident representative in treatments at this he facility. (initial representative initial 4. I understand that Directive that I have	function of the bladder, h blood pressure, Takotsubo fibrillation, and organ ay MDS (Minimum Data Set) as being mildly impaired in life decisions. cal record revealed the Acknowledgement" form for s form documented the E FOLLOWING FOUR ace your initials after each are were 5 statements, not 4 ented there were.) In written materials on and about my right to accept eatments (initialed). entative initialed this line. Treed of my rights to formulate accept initialed in the control of the c	F	578			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01	/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		7300	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE IMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	from my physician a this decision(representative initial PLEASE CHECK OF STATEMENTS: () I HAVE executh the second of the complete of the clinical evidence that the reductive of the complete of the	inded that I also seek advice and attorney prior to making initialed). The resident ed this line. NE OF THE FOLLOWING ted an Advance Directive - ed for this resident. executed an Advance ce in obtaining Advance () No. The box for, "No" e resident representative is form on 12/20/19. al record failed to reveal any sident had Advance prehensive care plan ted 12/13/19 for "Advanced intervention documented, intervention documented, intervention documented, intervention, ASM #2 (the ASM #3 (the corporate (the Medical Director) were indings. No further yided by the end of the	F	578			
	happens when extre	eme stress leads to heart igh rare, this condition is					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		,	01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578	Information obtaine	ost-menopausal women.	F 5	78		
	12/27/18; diagnoses to high blood pression, anxiety disease. The quart with an ARD (Asses 10/31/19 coded the impaired in ability to A review of the clinic "Advance Directive"	as admitted to the facility on a included but are not limited bure, dementia with behaviors, disorder and chronic kidney erly MDS (Minimum Data Set) assment Reference Date) of resident as being mildly make daily life decisions. cal record revealed the Acknowledgement" form for form documented the				
	STATEMENTS. Pla statement: (Note, that the form document 1. I have been given Advance Directives or refuse medical transfer.)	E FOLLOWING FOUR ace your initials after each here were 5 statements, not 4 ented there were.) In written materials on and about my right to accept eatments(initialed). entative initialed this line.				
	Advance Directives The resident repres 3. I understand tha	entative initialed this line. t I am not required to have an norder to receive medical				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01.	/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	facility(initialerepresentative initialerepresentative initialerepresentative initialerepresentative initialextent permitted by The resident representative initialextent physician at this decision(representative initialextent place of the CHECK OF STATEMENTS: () I HAVE executative bounded in the properties of the composition of the clinical process. A review of the clinical process. A review of the composition of	d). The resident ed this line. the terms of any Advance executed will be followed by ty and my caregivers to the aw(initialed). entative initialed this line. ded that I also seek advice and attorney prior to making initialed). The resident ed this line. NE OF THE FOLLOWING ted an Advance Directive - ed for this resident. executed an Advance () No. The box for "No" eresident representative is form on 12/27/18. all record failed to reveal any sident had Advance orehensive care plan ted 1/1/19 for "Advanced intervention documented,"	F	578			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	survey. 7. Resident #44 was 8/28/15 with diagnos limited to: dementia decline) (1), osteoart in the joints) (2), and of mind with feelings and hopelessness) (3. The most recent MD assessment (after the assessment, with an date) of 11/14/19, co a 6 out of 15 on the Emental status) score, severely cognitively if MDS Section G-func resident as requiring mobility, locomotion eating. Resident coot transfer, toilet use and Review of Resident #4 acknowledgement for revealed a check in the executed an advance advance directive was paper or electronic monducted with OSM social worker. When Resident #44's executed #4 stated, "There is a redvance directive." It is responsible for obtain	admitted to the facility on es that included but were not (progressive state of mental hritis (degenerative changes depression (dejected state of sadness, discouragement 3). S (minimum data set) e event), a quarterly ARD (assessment reference ded Resident #44 as scoring BIMS (brief interview for indicating the resident was mpaired. A review of the tional status coded the extensive assistance for bed on/off unit, dressing, and led as total dependence for id personal hygiene. #44's advance directive, rm, in the clinical record, he box next to "I have e directive." No copy of an is evidenced in either the nedical record. PM, an interview was (other staff member) #4, the asked to provide a copy of uted advance directive, OSM no copy of the executed	F 5	78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			' '	E SURVEY PLETED			
		495227	B. WING			01	/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRE 7300 FOREST A RICHMOND, V		·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EA	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO ISS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 578	advance directive d On 1/15/20 at 1:32 conducted with OSI When asked about, directive" on the "Ac Acknowledgement" means they either h full measures or the resuscitate). I unde the chart- the DNR's directives. I went by resuscitation) forms check the box for "e directive", we ask for copy obtained eithe business chart. The the documentation. asked if staff have a at all times of day, o is locked up at night On 1/15/20 at 2:35 have no copy of an Resident #44 in the ASM #1, the admini corporate represent above concerns on An interview was co AM with ASM #1, th about executed adv medical record, ASI admissions office di	PM, an interview was M #1, the admissions director. "I have executed an advance dvance Directive form, OSM #1 stated, "It ave an advance directive with ey sign a DNR (do not extand now that what I put in so, are separate from advance by the CPR (cardiopulmonary." OSM #1 stated, When we executed an advance or a copy. We would put the rin the paper chart or in the executed an advance or a copy. We would put the rin the paper chart or in the executed an advance or a copy. We would put the rin the paper chart or in the executed an advance or a copy. We would put the rin the paper chart or in the executed an advance or a copy. We would put the rin the paper chart or in the executed an advance or a copy. When the paper chart or in the executed an advance of the business chart DSM #1 stated, "No, the office the paper chart or in the paper chart or in the paper chart or in the executed an advance of the business chart DSM #1 stated, "No, the office the paper chart or in the paper cha	F	578			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 578	The facility's "Advar documents "Informaresident has execut be displayed proming References: (1) Barron's Diction Non-Medical Reade Chapman, page 15-(2) Barron Dictional edition, Rothenberg (3) Barron's Diction Non-Medical Reade Chapman, page 15-(2) Barron's Diction Non-Medical Reade Chapman, page 15-(3) Barron's Diction Non-Medical Reade Chapman, page 15-(4) Barron's Diction Non-Medical Reade Chapman, page 15-(5) Barron's Diction Non-Medical Reade Chapman, page 15-(5) Barron's Diction Non-Medical Reade Chapman, page 15-(6) Barron's Diction Non-Medical Reade Chapman, page 15-(7) Barr	on was provided prior to exit. Ince Directives" policy ation about whether or not the ed an advance directive shall mently in the medical record." Incomparison of Medical Terms for the er, 7th edition, Rothenberg and 4. Incomparison of Medical Terms, 7th and Kaplan, page 420. Incomparison of Medical Terms for the er, 7th edition, Rothenberg and er, 7th edition, Rothenberg and	F 578	,		
	MDS Section G-fun resident as requiring mobility, transfer, lo	impaired. A review of the ctional status coded the g extensive assistance for bed comotion on/off unit, dressing, anal hygiene. Resident coded sion for eating.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			01/	16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER	•	STREET ADDRESS, 7300 FOREST AVE RICHMOND, VA		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	form for Resident #4' revealed a check in ban advance directive directive for Resident the paper or electron On 1/15/20 at 12:50 conducted with OSM social worker. When Resident #47's exect #4 stated, "There is radvance directive." Versponsible for obtain executed advance di "The admissions directive do On 1/15/20 at 1:32 P conducted with OSM When asked about, "directive" on the "Advance directive" on the "Advance directiv	irective, acknowledgement 7, in the clinical record, box next to, "I have executed ." No copy of an advance t #47 was evidenced in either ic medical record. PM, an interview was (other staff member) #4, the asked to provide a copy of uted advance directive, OSM no copy of the executed When asked who is ning copies of the residents' rectives, OSM #4 stated, ctor is responsible for the cumentation." M, an interview was #1, the admissions director. I have executed an advance	F	578	DEFICIENCY)		
	the chart- the DNR's, directives. I went by resuscitation) forms.' check the box for "ex directive", we ask for copy either in the parchart. The business documentation. I will asked if staff have act all times of day, Or is locked up at night.'	stand now that what I put in are separate from advance the CPR (cardiopulmonary OSM #1 stated, When we recuted an advance a copy. We would put the per chart or in the business chart might contain the I look for it there." When recess to the business chart SM #1 stated, "No, the office					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 578	#47 in the business ASM #1, the administ corporate represents above concerns on the second and with ASM #1, the about executed advanted and admissions office did difference between a status." No further information. The facility's "Advant documents "Information and the second and the seco	ance directive for Resident chart." strator, and ASM #3, the ative were made aware of the I/15/20 at 5:05 PM. Inducted on 1/16/20 at 11:28 and ance directive location in the If a tated, "It seems the Id not understand	F 578	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING	 		1/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	The most recent MD assessment (after the assessment, with art date) of 11/22/19, or 3 out of 15 on the Bi status) score, indicate cognitively impaired Section G-functional requiring extensive attransfer, locomotion personal hygiene. Feeder dependence for locological worker of the executed an advance directive which documented attransfer of the executed an advance directive for evidenced in either the medical record. On 1/15/20 at 12:50 conducted with OSM social worker. When Resident #80's executed advance directive." responsible in obtain executed advance directive do On 1/15/20 at 1:32 Feeder dependenced with OSM When asked what, "directive" on the "Addirective" on the "	distently above 140/90) (3). DS (minimum data set) the event), a quarterly to ARD (assessment reference toded the resident as scoring a time to resident was severely to A review of the MDS to status coded the resident as the assistance for bed mobility, to nunit, toilet use and the action off unit and dressing. #80's clinical record, revealed to acknowledgement form, to check in box next to "I have the directive." No copy of an to resident #80 was the paper or electronic PM, an interview was to (tother staff member) #4, the to asked to provide a copy of totted advance directive, OSM to copy of the executed When asked who is thing copies of residents' the course of the course of the totted to the totted to the totted to the course of the totted to the totted to the totted to the course of the totted to the totted t	F 57	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 578	"It means they eithe with full measures o resuscitate). I under the chart- the DNR's directives. I went by resuscitation) forms check the box for "e directive", we ask for copy either in the part chart. The business documentation for R there." When asked business chart at all "No, the office is loc." On 1/15/20 at 2:35 F have no copy of adv. #80 in the business. ASM #1, the administ corporate represents above concerns on the concerns on the concerns on the concerns of the	r have an advance directive r they sign a DNR (do not restand now that what I put in are separate from advance of the CPR (cardiopulmonary)." OSM #1 stated, When we executed an advance of a copy. We would put the apper chart or in the business of chart might contain the desident #80. I will look for it I staff have access to the times of day, OSM #1 stated, ked up at night." PM, OSM #1 stated, "We ance directive for Resident chart."	F 5	78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING		0	1/16/2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 578	Non-Medical Read Chapman, page 18 (2) Barron Dictions edition, Rothenber (3) Barron's Diction Non-Medical Read Chapman, page 28 10. Resident #81 11/1/17 with diagnoral limited to: COPD (disease a non-reversibrillation (a rapid/of the heart) (2), gleye leading to blur. The most recent Massessment (after assessment, with a date) of 12/5/19, coldinary of the heart (after assessment, with a date) of 12/5/19, coldinary of the mental status) scorognitively intact. G-functional status requiring supervision assistance for bed requiring extensive in corridor, locomouse and personal has review of Resident an advance directively which documented executed an advance directive manual results of the secuted an advance directive which documented executed an advance directive manual results of the secuted and results of the secuted and results of the secuted and results of the secuted an advance directive manual results of the secuted and results of the se	parary of Medical Terms for the er, 7th edition, Rothenberg and 64. ary of Medical Terms, 7th g and Kaplan, page 157. pary of Medical Terms for the er, 7th edition, Rothenberg and 62. was admitted to the facility on poses that included but were not chronic obstructive pulmonary ersible lung disease) (1), atrial random contraction of top part aucoma (high pressure in the red vision or blindness) (3). DS (minimum data set) the event), a quarterly an ARD (assessment reference poded the resident as scoring a BIMS (brief interview for re, indicating the resident was an are indicating the resident was an for eating and limited mobility, walk in room; assistance for transfer, walk the tion on/off unit, dressing, toilet by in a check in box next to "I have not edirective." No copy of an was evidenced in either the	F	578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	conducted with OSM social worker. When of copy of Resident # directive, OSM #4 state executed advance diresponsible in obtaining executed advance directive down of the admissions directive on the "Adward Acknowledgement" for "It means they either with full measures or resuscitate). I understhe chart- the DNR's directives. I went by resuscitation) forms." check the box for "extendirective", we ask for copy either in the parchart. The business documentation for Rethere." When asked business chart at all to "No, the office is lock" on 1/15/20 at 2:35 P	PM, an interview was (other staff member) #4, the asked to provide evidence #81's executed advance ated, "There is no copy of the rective." When asked who is ing copies of residents' rectives, OSM #4 stated, actor is responsible for the cumentation." M, an interview was #1, the admissions director. have executed an advance vance Directive orm, meant, OSM #1 stated, have an advance directive they sign a DNR (do not stand now that what I put in are separate from advance the CPR (cardiopulmonary 'OSM #1 stated, When we recuted an advance a copy. We would put the oer chart or in the business chart might contain the esident #81. I will look for it if staff have access to the times of day, OSM #1 stated,	F 5	78			
		trator, and ASM #3, the tive were made aware of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 578	AM with ASM #1, the about executed advanced record, AS admissions office difference between status." No further information of the facility's "Advanced documents "Informated resident has executed be displayed promination." References: (1) Barron's Diction Non-Medical Readd Chapman, page 12 (2) Barron Diction edition, Rothenberg (3) Barron's Diction (3) Barron's Diction (4)	ne administrator. When asked vance directive location in the M #1 stated, "It seems the id not understand the advance directive and code on was provided prior to exit. Ince Directives" policy ation about whether or not the ted an advance directive shall mently in the medical record." ary of Medical Terms for the er, 7th edition, Rothenberg and 0. ary of Medical Terms, 7th g and Kaplan, page 54. ary of Medical Terms for the er, 7th edition, Rothenberg and of Medical Terms for the er, 7th edition, Rothenberg and of Medical Terms for the er, 7th edition, Rothenberg and	F 5	78			
	11. Resident # 73 diagnoses that inclustroke, muscle wear difficulties. Resident # 73's moset], a significant of ARD (assessment coded Resident # 7 interview for mental - 15, 13 - being cogdecisions.	was admitted to the facility with uded but were not limited to: kness and swallowing st recent MDS [minimum data nange assessment with an reference date) of 12/08/19, is as scoring a 13 on the brief I status (BIMS) of a score of 0 unitively intact for making daily					
		e care plan for Resident # 73 locumented, "Focus: Advance					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _		01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 578	Continued From pa	ge 31	F 5	78		
		ated: 09/03/2019." Under cumented, "Full Code. Date 9."				
	73 revealed a document of the revealed a documen	r clinical record for Resident # ment titled, "Advance Directive lated 12/02/2019, for Resident e Directive Acknowledgment" I HAVE executed an Advance				
	paper clinical record	(electronic health record) and d for Resident # 73 failed to the advance directive.				
	member] # 4, the so 12:51 p.m. When a acknowledgement o OSM # 4 stated she admissions staff me misconception that	onducted with OSM [other staff ocial worker on 01/15/2020 at asked who obtains the of the advanced directive, a had spoken to the ember that there was a the DNR [do not resuscitate] e advanced directive.				
	admissions staff me "Advanced Directive Resident # 73 was # 1 stated that befo understanding that not resuscitate] was Directive. OSM # 1 today that it wasn't stated that many of Directive Acknowled and the residents m directive. When ask	ember, on 01/15/2020. The exacknowledgement" for reviewed with OSM # 1. OSM are today, it was her the completion of a DNR [do as the same as an Advanced stated that she just found out the same thing. OSM # 1 the forms (Advanced dgment) forms are incorrect may not have an advanced are directive, OSM # 1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/	16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From pag	ge 32	F	578			
	[administrative staff	# 2, director of nursing, were					
	No further information	on was provided prior to exit.					
	with diagnoses that	vas admitted to the facility included but were not limited od pressure and muscle					
	set], an admission a (assessment referer Resident # 53 as so interview for mental	st recent MDS [minimum data ssessment with an ARD nce date) of 11/27/19, coded oring a 14 on the brief status (BIMS) of a score of 0 nitively intact for making daily					
	dated 12/06/2019 do Directive. Date Initia	care plan for Resident # 53 ocumented, "Focus: Advance ated: 12/06/2019." Under cumented, "Full Code Date b."					
	53 revealed a docum Acknowledgment" d # 53. The Advance form documented, "I FOLLOWING FOUR initials after each sta given written materia about my right to act treatments.	clinical record for Resident # nent titled, "Advance Directive ated 12/02/2019 for Resident Directive Acknowledgment" PLEASE READ THE R STATEMENTS. Place your atement. [1] I have been als on Advance Directives and cept or refuse medical (for initials) [2] I have been to formulate an Advance					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3	3) DATE SURVEY COMPLETED
		495227	B. WING _			01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 578	I am not required to order to receive med care facility that the terms of any have executed will be facility and my cared by law (for recommended that I physician and attorn decision (for the "Advance Direct Resident # 53 revea were not initiated an executed an Advance Review of the EHR paper clinical record evidence a copy of the the same as the misconception that the was the same as the latest the same as an Advistated that she just the same thing. She	r initials [3] I understand that have an Advance Directive in dical treatments at this health (for initials) [4] I understand Advance Directive that I be followed by the health care givers to the extent permitted initials) [5] It was seek advice from my bey prior to making this or initials). Further review of initials in the statement of the advance directive. (electronic health record) and for Resident #53 failed to the advance directive. Inducted with OSM [other staff cial worker on 01/15/2020 at sked who obtains the form that there was a the DNR [do not resuscitate] and advanced directive. Inducted with OSM #1 mber, on 01/15/2020. The exactnowledgement for eviewed with OSM #1. OSM	F	578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/1	6/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE 7300 FOREST AVE RICHMOND, VA 23226	E, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTI' CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE	
F 578	have an advanced di had a copy of Reside OSM # 1 stated no. regarding the develo directive was provide Resident # 53's resp stated no. On 01/15/2020 at ap [administrative staff radministrator, ASM # made aware of the fill. No further information. 13. Resident #57 was 11/21/2019. Her diagonal replacement surgery morbid obesity. Resiminimum Data Set (Medicare 5 Day Assert Reference Date (ARI Interview for Mental Resident #57 at a 15 Resident #57 was control of the sident #57 was c	and the residents may not rective. When asked if they ent # 53's advance directive, When asked if information pment of an advance ed to Resident # 53 and/or onsible party, OSM # 1 proximately 5:40 p.m. ASM member] # 1, the # 2, director of nursing, were ndings. In was provided prior to exit.	F		-iclency)			
	On the morning of 0° were asked to locate Directive, or else pro Resident #57 had de Facility staff provided "Advanced Directive middle area of the do statement was typed	Acknowledgement." In the ocument, the following						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		ي ا	1/16/2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 578	The first box, indice had been execute #57's form. An interview was of Member (OSM) #4 1/15/2020 at 12:50 the acknowledgen OSM #4 stated she admissions staff or misconception that was the same as the same as the same as the same as an Act of	d an Advanced Directive ecuted an Advanced Directive d, was checked on Resident conducted with Other Staff d, the social worker on 1 p.m. When asked who obtains ment of the advanced directive, e had spoken to the member that there was a t the DNR (do not resuscitate) the advanced directive. Conducted with OSM #1, member, on 1/15/2020. The ve Acknowledgement" for reviewed with OSM #1. OSM ore today, it was her the completion of a DNR was divanced Directive. She stated dout today that it wasn't the any of the forms (Advanced edgment) forms are incorrect may not have an advanced of Resident #57's advanced ested at this time. 2:44 p.m., OSM #1 stated that the treation of the difference between an ested of the difference between an	F 5	578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/	16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300 FOF	ADDRESS, CITY, STATE, ZIP CODE REST AVE DND, VA 23226	•		
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 578	Administrator, and AS Nursing, were informed of day meeting on 01 documentation was put 14. Resident #136 was	Member (ASM) #1, the SM #2, the Director of ed of the findings at the end /16/2020. No further	F 5	78				
	not limited to: Alzhein loss of mental ability accompanied by persemotional instability) stroke. The most recent MDS	ner's disease (a progressive and function, often conality changes and (1), high blood pressure, and						
	assessment reference the resident as having memories problems a	erly assessment, with an e date of 12/26/19, coded g both short and long-term and being moderately ly cognitive decisions.						
	"Advanced Directive adated, 2/5/18 that document advanced directive	as reviewed. There was an Acknowledgement form cumented the resident had e. Further review of the o evidence a copy of the directive.						
	A copy of the residen requested on 1/15/20	t's advanced directive was 20.						
	#4, the social worker,	OSM (other staff member) informed this surveyor that opy of Resident # 136's						
	Administrative staff m	nember (ASM) #1, the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			1/16/2020	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 578	Continued From pag		F 5	78			
	ASM #3, the corpora	#2, the director of nursing, te nurse and ASM #4 the is made aware of the above 0 at 5:42 p.m.					
		ry of Medical Terms, 5th and Chapman, page 26.					
	7/31/17 with diagnos limited to: myastheni characterized by chr weakness especially but also affecting the limbs (1)], Parkinson progressive neurolog by resting tremor, sh rolling motions of the weakness, sometime	onic fatigability and in the face and neck region, muscles of the trunk and					
	assessment, a quart assessment reference the resident as scori interview for mental	S (minimum data set) erly assessment, with an ee date of 11/14/19, coded ng a "14" on the BIMS (brief status) score, indicating she ng cognitive decisions.					
	"Advanced Directive dated, 7/31/17 that of an advanced directive	as reviewed. There was an Acknowledgement form ocumented the resident had e. Further review of the to evidence a copy of the directive.					
	A copy of the resider requested on 1/15/20	nt's advanced directive was 020.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			, ,	(X3) DATE SURVEY COMPLETED	
					01/16/2020		
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	Continued From pag	ge 38	F 57	78			
	#4, the social worke they did not have a dadvanced directive. Administrative staff is administrator, ASM is ASM #3, the corpora medical director, was concern on 1/15/202 On 1/16/2020 at 10: presented for review Power of Attorney of the document failed documentation related to the document failed documentation related to the properties of the document failed documentation related to the following properties of the document failed documentation related to the following properties of the following prop	on a.m., a document was a titled, "Durable General for (Resident #40)." Review of to evidence any ed to an advanced directive. In was provided prior to exit. In yof Medical Terms for the graph of Medical Terms for t					
	The most recent MD assessment, a quart assessment reference	by personality changes and (1), and diabetes. S (minimum data set) terly assessment, with an ce date of 11/21/19, coded ing a "7" on the BIMS (brief					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495227		B. WING		01/16/2020	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 578	Continued From page	e 39 tatus) score indicating she	F 578	3		
		d to make daily cognitive				
	"Advanced Directive Adated, 7/31/17 that do an advanced directive	as reviewed. There was an Acknowledgement form ocumented the resident had e. Further review of the o evidence a copy of the directive.				
	A copy of the resident requested on 1/15/20	t's advanced directive was 20.				
	#4, the social worker,	OSM (other staff member) informed this surveyor that opy of Resident # 45's				
	guardianship for Resi The paperwork docur (Resident #45)'s Adva attached to this Order effect with respect to daughter) formerly kn	of a legal document for dent #45 was presented. mented in part, "A. that the ance Medical Directive r as Exhibit A is in full legal the appointment of (name of lown as (name of daughter), ent for (Resident #45)." A attached to this				
	administrator, ASM #4 ASM #3, the corporat	nember (ASM) #1, the 2, the director of nursing, the nurse and ASM #4 the made aware of the above 0 at 5:42 p.m.				
	No further information	n was provided prior to exit.				
	References:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495227	B. WING		01/16/2020		
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
F 578	Continued From pag	e 40	F 578	3			
	edition, Rothenberg	ry of Medical Terms, 5th and Chapman, page 26.					
F 600 SS=D	Free from Abuse and CFR(s): 483.12(a)(1)	•	F 600		2/17/20		
	Exploitation The resident has the neglect, misappropria and exploitation as d includes but is not lin corporal punishment any physical or chem treat the resident's m §483.12(a) The facili §483.12(a)(1) Not us physical abuse, corp involuntary seclusion. This REQUIREMEN by: Based on staff intervand clinical record rethe facility staff failed residents, (Resident from abuse. Resident from abuse from Resident #712 Reacher on 2/27/19. The findings include: 1. A FRI (Facility Rep 1/9/19, documented	ty must- e verbal, mental, sexual, or oral punishment, or i; Γ is not met as evidenced view, facility document review view, it was determined that I to ensure two of sixty #462 and #712) were free t #140 stuck Resident #462 face, on 1/9/19. The facility that Resident #712 was free sident #22; Resident #22 multiple times with a		F600-D Free from Abuse and Neglec 1) Corrective Action for those reside found to be affected by the alleged deficient practice. Residents # 462 an #712 have since been discharged fror the facility. Resident #22 remains in facility in a room by herself with psych services. There have been no recent altercations or issues with her. Reside #140 remains in facility with no behav issues. 2) Corrective Actions taken for resid with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility h	ents d m ent ioral ents d e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	resident altercation. Incident: "Resident #4 chair in hallway. Res #462 on the left side of the "FRI Final Report documented in part," assistant) #8 witnesse Resident #462 on the was no injury noted to residents were immediated. The resident remembered day. The resident on substantiated." The facility's abuse portion Presidents have the rigneglect, misappropriate exploitation. This incomplete freedom from corporate seclusion, verbal, meabuse, and physical corequired to treat the readbase defined in the of injury" and "instanci irrespective of any meabuse physical harm, Resident # 462 was a 7/20/17, with diagnos not limited to: demense mental decline) (1), Copulmonary disease a	dent type: resident on njuries: "No." Describe 162 was sitting in her wheel ident #140 slapped Resident of the face." "" dated, 1/14/19, CNA (certified nursing ed Resident #140 strike left side of her face. There is either resident and both diately separated. Neither the incident the following resident abuse was Dicy revised 2017 and titled or abuse, tion of resident property and udes but is not limited to all punishment, involuntary intal, sexual or physical or chemical restraint not esident's symptoms." policy as "the willful infliction is of abuse of all residents, ental or physical condition, pain or mental anguish." Idmitted to the facility on es that included but were tia (progressive state of OPD (chronic obstructive non-reversible lung disease) sorder (mental disorder ortions of reality,	F 6	the potential to be affected. of Nursing or designee will a current residents with report altercations. 3) Systemic Changes put i ensure the alleged deficient not recur. In-service for the I Nurses will be completed by of Nursing or designee moni Residents for agitation and e Care plans to be updated at the incident and a psychoso assessment to be completed is involved in a resident to re altercation. 4) Corrective Actions taken with potential to be affected deficient practice. Director o Designee will complete resid resident altercation audits w monthly x 3. Plan of correc information and audits will b the quality assurance and pe improvement process month 5) Date of compliance 2/11	into place to practice does Licensed the Director itoring escalation. The time of cial dif a resident esident for residents d by alleged f Nursing/dent to eekly x 4 theretion e reviewed in erformance only.	5	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/	/16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Resident # 462's modata set) assessment with an ARD (assess 12/27/18, coded the 15 on the BIMS (briescore, indicating the impaired cognition. A G-functional status or requiring extensive a locomotion on/off the personal hygiene anteating. A nurse's progress in clinical record dated, documented in part, related to Resident bof the face by another at this time. No commowithin normal limits." The care plan for Redocumented in part, agitation/aggression The Interventions da "Remove from public disruptive/unaccepta with all activities." Resident #140 was a 4/10/17 with diagnos limited to: dementia decline) (1), anxiety apprehension and fedepression (feelings or hopelessness) (3)	st recent MDS (minimum at, a quarterly assessment, ament reference date) of resident as scoring a 7 out of a interview for mental status) resident had severely a review of the MDS Section coded the resident as assistance for bed mobility, a unit, dressing, toilet use, a requiring supervision in cote in Resident #462's and requiring supervision in cote in Resident #462's and requiring supervision in cote in Resident #462's and plaints of pain. Skin color is color is color is color in section and plaints of pain. Skin color is color in the state of the score in the score i	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495227 B. WING			01/	16/2020		
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			7300	EET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226	•	
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F 600	date) of 2/14/19, cod a 3 out of 15 on the Emental status) score, severely impaired co Section G-functional requiring limited assi in corridor, dressing, and requiring supervision, locomotion on The care plan dated documented in part, related to Dementia Indated 7/31/19 documappropriate response Interventions dated 4 "Approach/speak in amanner." Problem: "depression/sadness anxiety disorder revise Interventions revised "Offered choices to ewhenever possible, as ordered." Resider with Resider A nurse's progress not in Resident #140's clipart, "Change in concresident. This change 1/9/19. Since this state Both residents were diffused. Resident according to the second of the second o	Re event), a quarterly ARD (assessment reference ed Resident #140 as scoring BIMS (brief interview for indicating the resident had gnition. A review of the MDS status coded the resident as stance for bed mobility, walk toilet use, personal hygiene ision in transfer, walking in 'off unit and eating. 1/1/19, for Resident #140 Problem: "Cognitive loss revised 6/15/18." The Goal mented, "Will display to situation." The indicators of related to depression, sed 9/3/18." The 5/11/19, documented, inhance sense of control Psych consult and treatment in #140's care plan was not 19, resident-to-resident	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			1/16/2020	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	•	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	PM with LPN (licens When asked definition "It can be physically verbal." When asker resident is that consistated, "Yes, that's at the process staff followers down and inform matcompletes paperworthe care plan." An interview was condam with Resident #1 remembered any phanother resident, Redon't." ASM (Administrative administrator and AS representative were concerns on 1/15/20 No further information References: (1) Barron's Dictionar Non-Medical Reader Chapman, page 154 (2) Barron Dictionar edition, Rothenberg (3) Barron's Dictionar	anducted on 1/14/20 at 4:35 ed practical nurse) #11. on of abuse, LPN #11 stated, hitting someone, sexual or d if a resident, hits another idered abuse, LPN #11 buse." When asked about ows when abuse occurs, LPN #11 e the residents, calm them mager. The manager k for reporting and updates anducted on 1/15/20 at 9:28 anducted on 1/15/20	F 60				
	2. Resident #712, w	rho was no longer residing in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16/2020	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 600	diagnoses include be cerebrovascular dise hemiplegia, aphasia unspecified hand, de intracranial hemorrh subarachnoid hemore communication defice (Minimum Data Set) Reference Date) of being moderately im decision-making. The requiring total care for extensive care for be hygiene; supervision incontinent of bowel Resident #22 was as 12/27/18; diagnoses high blood pressure, depression, anxiety disease. The quarte with an ARD (Assess 10/31/19 coded the impaired in ability to The resident was co care for bathing; limit dressing, and toiletin ambulation, eating a continent of bowel a A review of the facilit Program" document right to be free from misappropriation of rexploitation. This infreedom from corpor seclusion, verbal, me	itted to the facility on 5/4/17; ut are not limited to ease, convulsions, dysphagia, contracture of epression, non-traumatic age, non-traumatic rhage, and cognitive etc. The quarterly MDS with an ARD (Assessment 7/25/19 coded the resident as paired for daily ne resident was coded as or bathing and toileting; ed mobility, dressing, and a for eating; and was and bladder. Idmitted to the facility on include but are not limited to dementia with behaviors, disorder and chronic kidney erly MDS (Minimum Data Set) sment Reference Date) of resident as being mildly make daily life decisions. It ded as requiring extensive ted assistance for transfers, ag; supervision for not hygiene; and was not bladder. It policy, "Abuse Prevention ed, "Our residents have the	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER	1	STREET ADDRESS, CITY, STATE, ZI 7300 FOREST AVE RICHMOND, VA 23226	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE	
F 600	part of the resident al administration will: 1 abuse by anyone inclimited to: facility staff consultants, voluntee agencies, family men friends, visitors, or ar Review of a Facility F 2/27/19 documented, altercation happened residentsResidents (Resident #712) sent assessment." A review of the follow documented, "On We 2/27/19), approximate (Licensed Practical Nurse call system for entering room, (Resident #712). (Resident #712). (Resident #712). (Resident #712). At 1 started swinging read struck her 4-5 times it	esident's symptoms. As puse prevention, the a Protect our residents from uding, but not necessarily for other residents, rs, staff from other others, legal representatives, by other individual." Reported Incident (FRI) dated "An (sic) physical between two were separated and made assessed for injury. to hospital for further up report, dated 3/4/19, and seday 3/27/19 (sic, sely 5:00pm, (LPN #12) urse) responded to the resident (#712). Upon dent #22) had a reacher in ting on side of bed of esident #712) had blood on the complete (LPN #12) attempted to off of bed and away from this point (Resident #712) and pefore LPN (#12) could and secure the reacher LPN called out for	F6		ENCY)		
	Assistant) and (LPN assisted with leading room. During this tim (Resident #22) said down." Medical care	#1) bot (sic) responded and (Resident #22) out of the le period of being separated I told her to turn her TV was given to (Resident to ER (emergency room) to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16/2020	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 600	#712) was complain showed signs such a areas, skin tear, whi from being struck methat were witnessed transferred back to uno broken bones. They arrived before (transferred to ER. (not decided if he will (Resident #22) and roommates. It has be (Resident #712) was aggression." A review of the clinic revealed the followir - 2/27/19 at 4:45 PM related to Upon responserved resident be reacher by her room nurse attempted to sattempt, the roommates attempted to sattempt, the roommates attempted to has welling, redness to of head, laceration to laceration x 2 w/ swelling, redness to lef noted related to chaonset of pain noted. at 10 on a 1-10 scalright hand/knuckles,	er hand which (Resident ing of pain. (Resident #712) as redness of skin in multiple ch can be assumed to be any times beyond the 4-5 hits. (Resident #712) was us in the same evening with he police were notified and Resident #712) was Resident #712) husband has a be pressing charges. (Resident #712) are no longer open substantiated the (sic) as the victim of (Resident #712, was resident #712).	F 600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495227		B. WING	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	oriented x 3, no char upon assessment, N initiated at this time.' - 2/27/19 at 5:00 PM doctor/responsible p Administration, state agencies notified, factor and complete to affect x 1 for c/of pain to rig N.O.O. (new order of [emergency room] for party] aware" - 2/28/19 at 5:18 AM facility via ambulance PM) with husband at (1) 200mg (milligram 8 hours PRN (as neat this time. 2 (two) (activities of daily living known and voice con and chest bruised. Cand bridge of nose. drainage noted. Rai right forehead. Pt retime. Stated she just assessments initiate Pt noted eating snac during shift. Inconting Repositioned with as or pain. Monitored for (head of bed) elevator. A hospital "Dischar"	: "Resident alert, verbal and ages in neuro status noted euro [neurological] checks : "MD/RP/SS (medical arty/social services), and law enforcement cility investigation initiated. It dareas, resident medicated aght hand, will monitor. It bitained) send resident to ER or evaluation, RP [responsible at 2300 (2/27/19 at 11:00 at side. New order - Ibuprofen as) 1-2 tablets by mouth every eded). No complaints of pain person assist with ADLs and person assist with ADLs and person assist with ADLs and person assist with and knuckles are as to left chin and fused ice application at this to wanted to rest. Neuro d. Full ROM to right hand. It wanted to rest. Neuro d. Full ROM to right hand. It wanted to bowel and bladder. It is sistance without discomfort requently during shift. HOB and Turned and repositioned.	F	600			
		sionsIbuprofen (Motrin) ottle 1-2 tablets every 8 hours					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, 7300 FOREST AVE RICHMOND, VA 23226	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	(X5) COMPLETION E DATE	
F 600	Contusions are areas in the soft tissues. The and bleeding in the inwill give you a painles contusions may stay weeks. There are no takes a few days to a service of the incide worker note dated 2/2 "Informed by staff that roommate and receive hematoma. In to see roommate was physic Prior to conversation, separated and put in calm during conversa anticipating being ser Provided support and indicated she was no Encouraged resident and she indicated she emotionally. Spoke we discuss situation. Infinad been contacted, wish for charges to be indicated that he wish the emergency room Assured RP that residents.	e deep bruise (contusion). Tof tenderness and swelling hey are the result of trauma jured area. Minor trauma is bruise; more severe painful and swollen for a few broken bones. This injury few weeks to heal." Int report revealed a social 27/19 that documented, tresident was struck by ed laceration and resident who confirmed that cally aggressive towards her. resident and roommate different rooms. Resident tion, but did state she was not to the emergency room. reassurance. Resident tin emotional distress. to express her concerns was not in distress with RP (name of RP) to formed RP that the police RP indicated that he did not be pressed; however, also need for resident to be sent to [ER] for evaluation.	F	500	DIENCY)		
	stated she was calm Advised resident that (counseling service g assist with managing incident; however, res by (counseling service	with resident again who and did not feel in danger. counseling services through roup) were available to emotions related to the sident declined to be seen e group), indicating she did esident stated she will let					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 600	supportive counselito whether or not he filed against resider that he did not wish continue to assist where a continue to the continue to a continue	she feel the need for ng. Inquired again with RP as e wished for charges to be nt's roommate. RP re-iterated for charges to be filed. Will with needs as they arise." sprehensive care plan entation or evidence of a elated to this incident. cal record for Resident #22 ented behaviors towards other e 2/27/19 incident and ng nurses notes: M: "Resident transferred to mber), RP aware. There are resident and resident denies sult of the incident at this time. h and monitor resident for the	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		495227	495227 B. WING			01/16/2020	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	pressure". She ta roommate being " as well as with he room which appear placement for her leave her door to to decrease possic Client makes no puill not lash out placed in a room would need to be passive and easy presents as some PTSD [post traum and, as such, can defensive action, physically defending which is not easily long term counsel change. Recommon or, if with rochosen in order to Client reports that but would enjoy e puzzles, coloring a A review of the corevealed no docureview or revision. Observation made 8:46 AM, revealed private room, but resident was up in had multiple person and the TV on. Resident was with the total private room, but resident TV on. Resident to the room and the TV on. Resident to the room with the TV on. Resident to the room with the total private room, but resident TV on. Resident the TV on.	meone raises my blood alked further about her former irritating" and difficult with staff rClient is currently in a private ars to be most appropriate at this time. She is choosing to her room shut most of the time bility of unpleasant interactions. bromises or guarantees that she re to rise again". If she is to be with a new roommate, she with a resident who is fairly to get along with. Client one with longstanding, chronic ratic stress disorder] symptoms be easily triggered into which in her case, results in ng herself. This is a condition or remediated and would require ing services to begin to effect a mend that client remain in private or mate, one that is carefully or avoid future physical incidents. The she does not watch much TV intertaining herself with word or other similar activities" Imprehensive care plan mentation or evidence of a related to this incident. The of Resident #22 on 1/15/20 at the resident to be in a semi without a roommate. The or her chair waiting for breakfast, or alitems in reach around her, resident #22 was dressed and or to the room had been closed.	F6				

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		495227	B. WING _			01/16/2020
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F 600	Continued From page	ge 52	F 6	00		
	#8 (Licensed Praction resident has been resident has been resident that the reside with behaviors since She stated the reside activities without be that staff were surprobehavior towards Resident she had no towards any resident on 1/16/20 at 10:11 conducted with OSN Social Worker, and Member) the Admin "they were in a larged discussion over the disagreement related went to the other resthe TV by being phy (Resident 712) was The family was offer the police and pressed charges. To my known to previously display behaviors. She was triggers to a private be having to share a (Counseling service LCSW (licensed clirher. A psych (psychindicated she felt her from her choice of Twatching shows ago being counseled on	AM, in an interview with LPN cal Nurse), she stated that the esiding in a room by herself es with roommates. She lent has had no further issues to being in a room by herself. Ident does attend some social havior incidents. She stated rised by the resident's esident #22, as prior to this to displayed such behavior ints. AM, an interview was with a to that. (Administrative Staff istrator. OSM #4 stated that the room, and there was volume of the TV and a sed to that. (Resident #22) esident to make her turn down visically aggressive. She sent out for an evaluation. The triggers seems to space with someone else. It is group) came in, and an inical social worker) follows in its power of the room and the was gressive in nature. She was TV choices to calm her 22) watched police shows,				

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID IN	<u> </u>	
` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	D NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226	·		
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F 600	have seen. (Counse working with her. Shroommate after some documentation by the was appropriate for a no demonstrated out 8/19/19 documented new roommate). I docontact with the secontact with the seconta	She is better now from what I ling services group) is still le was given another	F	600				
		d to relieve pain, tenderness,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
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F 607 SS=D	tml Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The facilit	from by/druginfo/meds/a682159.h buse/Neglect Policies -(3) by must develop and	F 600		2/17/20	
	§483.12(b)(1) Prohib neglect, and exploited misappropriation of results in superior (S483.12(b)(2) Establistic to investigate any successive superior (S483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on staff intervand clinical record rethe facility staff failed policy to report an all hours for one of sixty sample, Resident #462 on 1/9/19 at 12:46 pulimplement the abuse allegation of abuse w [VDH-OLC (Virginia I Licensure / Certification reported until on 1/9/19).	tion of residents and resident property, sh policies and procedures on allegations, and e training as required at is not met as evidenced riew, facility document review view, it was determined that to implement the abuse regation of abuse within two residents in the survey of 2. The Facility reported ented that Resident #140 on the left side of the face m. The facility failed to		F607D Abuse and Neglect Policies 1) Corrective Action for those reside found to be affected by the alleged deficient practice. Resident # 462 has been discharged from facility. Resider #140 remains in facility and has not be involved in any altercations. 2) Corrective Actions taken for reside with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility he potential to be affected. The Direct of Nursing or designee will audit any current residents with reported allegation of abuse FRI (facility reported incident have been reported to OLC (Office of	nt een lents de le ave ettor tions t)	

NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
WESTPORT REHABILITATION AND NURSING CENTER STREET ADDRESS. CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226 SIMMARY STATEMENT OF DEPICIENCIES (READ HERICENCY MUST BE REFECREDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG F 607 Continued From page 55 The findings include: A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12-46 PM. Resident's involved (Resident #462 and (Resident #462 and sitting in her wheel chair in hallway. Resident #410 slapped Resident #462 can the left side of the face: "The FRI was faxed to VDH-OLC (Virginia Department of Health-Office Licensure / Certification) on 1/9/19 at 4:29 PM (three hours and forty-three minutes after alleged abuse). The facility's abuse policy revised July 2017 and titled "Abuse Investigation and Reporting" states "All reports of resident abuse, neglect, expibilation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly be reported to local, state and federal agencies (as defined by current regulations). Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury." Resident # 462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: demental (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). Resident # 462's most recent MDS (minimum			495227	B. WING _	B. WING			01/16/2020
CALL DESCRIPTION CENTER RICHMOND, VA 23226	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 607 Continued From page 55 The findings include: A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12:46 PM. Resident sinvolved (Resident #462) and (Resident #4140). Incident type: resident on resident alteration. Injuries: 7%. "D: Describe Incident: Resident #462 was sitting in her wheel chair in hallway. Resident #462 stafe and to VDH-OLC (Virginia Department of Health-Office Licensure / Certification) on 1/9/19 at 4:29 PM (three hours and forty-three minutes after alleged abuse). The facility's abuse policy revised July 2017 and titled "Abuse Investigation and Reporting" states "All reports of resident abuse, neglect, exploitation, mistreament and/or injuries of unknown source ("abuse") shall be promptly be reported to local, state and federal agencies (as defined by current regulations). Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury." Resident # 462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). Resident # 462's most recent MDS (minimum	WESTPOR	RT REHABII ITATION AN	D NURSING CENTER		73	300 FOREST AVE		
FREETIX TAG CONTINUED FROM LISC IDENTIFYING INFORMATION) F 607 Continued From page 55 The findings include: A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12-46 PM. Resident's involved (Resident #462) and (Resident #140). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: Resident #462 was stitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." The FRI was faxed to VDH-OLC (Virginia Department of Health-Office Licensure / Certification) on 1/9/19 at 4:29 PM (three hours and forty-three minutes after alleged abuse). The facility's abuse policy revised July 2017 and titled "Abuse Investigation and Reporting" states "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly be reported to local, state and federal agencies (as defined by current regulations). Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury." Resident # 462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). Resident # 462's most recent MDS (minimum)	112011 01	(TREMADIEMANON AN	D NONOMO SENTEN		R	ICHMOND, VA 23226		
The findings include: A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12:46 PM. Resident's involved (Resident #462) and (Resident #140). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: Resident #462 was sitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." The FRI was faxed to VDH-OLC (Virginia Department of Health-Office Licensure / Certification) on 1/9/19 at 4-29 PM (three hours and forty-three minutes after alleged abuse). The facility's abuse policy revised July 2017 and titled "Abuse Investigation and Reporting" states "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly be reported to local, state and federal agencies (as defined by current regulations). Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury." Resident # 462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). Resident # 462's most recent MDS (minimum)	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
A FRI (Facility Reported Incident) dated, 1/9/19, time: 12:46 PM. Resident sinvolved (Resident #462) and (Resident #140). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: Resident #462 was sitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." The FRI was faxed to VDH-OLC (Virginia Department of Health-Office Licensure / Certification) on 1/9/19 at 14:29 PM (three hours and forty-three minutes after alleged abuse). The facility's abuse policy revised July 2017 and titled "Abuse Investigation and Reporting" states "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse) shall be promptly be reported to local, state and federal agencies (as defined by current regulations). Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury." Resident # 462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). Resident # 462's most recent MDS (minimum)	F 607	Continued From page	e 55	F 6	607			
disturbances of thought) (3). Resident # 462's most recent MDS (minimum 5) Date of compliance-2/17/2020	F 607	The findings include: A FRI (Facility Report documented in part, '12:46 PM. Resident and (Resident #140). resident altercation. Incident: Resident #4 chair in hallway. Resident in hallway. Resident with the faxed to VDH-OLC (VHealth-Office Licensulat 4:29 PM (three hotafter alleged abuse). The facility's abuse putitled "Abuse Investig "All reports of resider exploitation, misapproporty, mistreatment source ("abuse") shallocal, state and feder current regulations). violation involves abuserious bodily injury. Resident # 462 was a 7/20/17 with diagnost limited to: dementia decline) (1), COPD (opulmonary disease a (2), Schizoaffective disease a find part of the part of t	ted Incident) dated, 1/9/19, "Incident date: 1/9/19, time: "Is involved (Resident #462) Incident type: resident on Injuries: "No." Describe 62 was sitting in her wheel sident #140 slapped Resident of the face." The FRI was /irginia Department of ure / Certification) on 1/9/19 urs and forty-three minutes olicy revised July 2017 and ation and Reporting" states at abuse, neglect, opriation of resident and/or injuries of unknown Il be promptly be reported to al agencies (as defined by Two hours if the alleged use OR has resulted in admitted to the facility on es that included but were not (progressive state of mental chronic obstructive non-reversible lung disease) lisorder (mental disorder	F	607	Services) and Ombudsman, VDH (VA dept. Of Health) within 2 hours. 3) Systemic Changes put into place to ensure the alleged deficient practice do not recur. Administrator or Designee win-service facility staff on reporting allegations of abuse, neglect, exploitate or mistreatment, including injuries of unknown origin and/or misappropriation resident property are to be reported immediately and Administrator or designee has no later than 2 hours aften the allegation of abuse is made, involvations injury to their Supervisor and the Supervisor will inform the Administrator submit FRI to OLC, APS, Ombudsman and VDH. 4) Corrective Actions taken for reside with potential to be affected by alleged deficient practice. The Administrator with audit grievances, be informed of allegations immediately and the Administrator or designee will submit F (facility report incident) within 2 hours to OLC, APS, Ombudsman and VDH when meets criteria weekly x 4 and then monthly x 3. The audits will be reviewed the quality assurance and performance improvement process for tracking/trending tracking/trending tracking/trending tracking/trending tracking/trending tracking/trending tracking/trending tracking/trending tracking/trending tracking/tracking/tracking/trending tracking/t	pes per	
with an ARD (assessment reference date) of 12/27/18, coded the resident as scoring a 7 out of		Resident # 462's mos data set) assessmen with an ARD (assess	ght) (3). st recent MDS (minimum t, a quarterly assessment, ment reference date) of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(2	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, 7300 FOREST AVE RICHMOND, VA 23226	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 607	Continued From page	e 56	F 6	607			
	15 on the BIMS (brie score, indicating the impaired cognition. A G-functional status or requiring extensive a locomotion on/off the personal hygiene and eating. A nurse's progress not clinical record dated, documented in part, related to Resident b of the face by another at this time. No composition of the face by another at this time. No composition in the face by another at this time. No composition in the face by another at this time. No composition of the face by another at this time. No composition of the face by another at this time. No composition of the face by another at this time. No composition of the face by another at this time. No composition of the face by another at the face by another	finterview for mental status) resident had severely review of the MDS Section oded the resident as ssistance for bed mobility, unit, dressing, toilet use, d requiring supervision in the in Resident # 462's 1/9/19 at 3:59 PM, 'Change in condition noted eing slapped on the left side or resident. No injury noted colaints of pain. Skin color is dmitted to the facility on es that included but were not (progressive state of mental disorder (mild to severe elings of panic) (2), of sadness, discouragement S (minimum data set) e event), a quarterly ARD (assessment reference ed Resident #140 as scoring BIMS (brief interview for indicating the resident had gnition. A review of the MDS status coded the resident as stance for bed mobility, walk toilet use, personal hygiene sion in transfer, walking in off unit and eating.					
	The care plan dated	1/1/19, for Resident #140					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		01/16/2020
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, 0.1.0.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 607	related to Dementia dated 7/31/19 docu appropriate respons Interventions dated "Approach/speak in manner." Problem: depression/sadness anxiety disorder revised choices to whenever possible, as ordered." Resid revised after the 1/5 incident with Resider the 1/5 incident with Resider the 1/9 incident with Resider the 1/9 incident with Resident #140's part, "Change in concession Resident being represident. This chart 1/9/19. Since this sent Both residents were diffused. Resident distress. Resident accepted." On 1/14/20 at 4:35 conducted with LPN #11. When asked a LPN #11 stated, "It someone, sexual or resident, hitting and considered abuse, abuse." When ask follows regarding reference with the modern and information of the control of	revised 6/15/18." The Goal mented, "Will display se to situation." The 4/17/17, documented, a calm, positive/reassuring "Indicators of se related to depression, vised 9/3/18." The ed 5/11/19, documented, enhance sense of control Psych consult and treatment ent #140's care plan was not 9/19, resident-to-resident	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16	/2020
	ROVIDER OR SUPPLIER	O NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 607	nursing, on 1/16/20 a time frame for reporting ASM #2 stated, "It is adid not report this FR I don't know what else. An interview was con AM with ASM #1, the the time frame to report this FR I facility time of this FRI [facility ASM #1, the administic corporate representation above concerns on 1/2 No further information References: (1) Barron's Dictionary Non-Medical Reader, Chapman, page 154. (2) Barron Dictionary edition, Rothenberg as (3) Barron's Dictionary	ducted with ASM nember) #2, the director of the 11:20 AM, regarding the ng allegations of abuse. It wo hours. I know that we within the regulated period. It to say about that." ducted on 1/16/20 at 11:28 administrator, when asked orting allegations of abuse, the work we have two hour rule as that was in effect 1/9/19, the try reported incident]. rator, and ASM) #3, the trive were made aware of the 15/20 at 5:05 PM. In was provided prior to exit. by of Medical Terms for the 7th edition, Rothenberg and of Medical Terms, 7th and Kaplan, page 120. By of Medical Terms for the 15 years of Medical Terms for the 16 years of Medical Terms for the 17 years of Medical Terms for the 17 years of Medical Terms for the 18 years of Medical Terms for the 19 year	F 60	7		
F 609 SS=D	Chapman, page 518. Reporting of Alleged CFR(s): 483.12(c)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		F 60	9	2/	17/20

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	involving abuse, nemistreatment, include source and misapporare reported immed hours after the allegsthat cause the allegserious bodily injury the events that cause abuse and do not rest the administrator of officials (including to adult protective sensor jurisdiction in lonaccordance with Staprocedures. §483.12(c)(4) Repositive stages accordance with Staprocedures.	re that all alleged violations glect, exploitation or ding injuries of unknown opriation of resident property, iately, but not later than 2 lation is made, if the events ation involve abuse or result in a, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides age-term care facilities) in ate law through established	F	F609 Reporting of Alleged Vi 1) Corrective Action for those found to be affected by the all deficient practice. Resident # been discharged from the face 2) Corrective Actions taken for with potential to be affected be deficient practice. Residents facility and those admitted to the potential to be affected. To f Nursing or designee will accurrent residents with reported of abuse FRI (facility reported)	residents lleged 462 has cility. or residents oy alleged within the facility have The Director udit any ed allegations		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01	/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	,	73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE LICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	titled "Abuse Investige" All reports of reside exploitation, misapp property, mistreatme source ("abuse") sha local, state and feder current regulations). violation involves abserious bodily injury. A FRI (Facility Report documented in part, 12:46 PM. Resident and (Resident #140) resident altercation. Incident: Resident # chair in hallway. Refused to VDH-OLC (Health-Office Licens at 4:29 PM (three heafter alleged abuse) Resident # 462 was 7/20/17 with diagnost limited to: demential decline) (1), COPD opulmonary diseases at (2), Schizoaffective characterized by distinuation.	policy revised July 2017 and gation and Reporting" states ent abuse, neglect, ropriation of resident ent and/or injuries of unknown all be promptly be reported to eral agencies (as defined by Two hours if the alleged cuse OR has resulted in " reted Incident) dated, 1/9/19, "Incident date: 1/9/19, time: at's involved (Resident #462)). Incident type: resident on Injuries: "No." Describe 462 was sitting in her wheel esident #140 slapped Resident e of the face." The FRI was (Virginia Department of sure / Certification) on 1/9/19 ours and forty-three minutes of that included but were not a (progressive state of mental (chronic obstructive a non-reversible lung disease) disorder (mental disorder tortions of reality, 19ht) (3).	F	609	have been reported to OLC (Office of Licensure), APS (Adult Protected Services) and Ombudsman, VDH (VA dept. Of Health) within 2 hours. 3) Systemic Changes put into place to ensure the alleged deficient practice do not recur. Administrator or Designee w in-service facility staff on reporting allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and/or misappropriation resident property are to be reported immediately and Administrator or designee has no later than 2 hours aft the allegation of abuse is made, involving serious injury to their Supervisor and the Supervisor will inform the Administrator submit FRI to OLC, APS, Ombudsman and VDH. 4) Monitoring of corrective action to ensure the alleged deficient practice do not recur. The Administrator will audit grievances, be informed of allegations immediately and the Administrator or designee will submit FRI (facility report incident) within 2 hours to OLC, APS, Ombudsman and VDH when meets criteria weekly x 4 and then monthly x 3. The audits will be reviewed in the quality assurance and performance improvem process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	on on of er es ne ones	
	Resident # 462's mo	ost recent MDS (minimum					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 609	with an ARD (asses 12/27/18, coded the 15 on the BIMS (bri score, indicating the impaired cognition. G-functional status requiring extensive locomotion on/off the personal hygiene are eating. A nurse's progress clinical record dated documented in part related to Resident of the face by anoth at this time. No corwithin normal limits. Resident #140 was 4/10/17 with diagno limited to: dementia decline) (1), anxiety apprehension and fidepression (feelings or hopelessness) (3) The most recent MI assessment (after the assessment, with all date) of 2/14/19, co a 3 out of 15 on the mental status) score severely impaired of Section G-functionar requiring limited assin corridor, dressing and requiring super	nt, a quarterly assessment, sment reference date) of a resident as scoring a 7 out of ef interview for mental status) a resident had severely A review of the MDS Section coded the resident as assistance for bed mobility, e unit, dressing, toilet use, and requiring supervision in the mote in Resident # 462's 14, 1/9/19 at 3:59 PM, 1 "Change in condition noted being slapped on the left side ther resident. No injury noted an plaints of pain. Skin color is " admitted to the facility on sees that included but were not a (progressive state of mental disorder (mild to severe eelings of panic) (2), as of sadness, discouragement	F 609		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495227	B. WING _			01/16/2020		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 609	documented in part, related to Dementia dated 7/31/19 documented in part, related to Dementia dated 7/31/19 documented in part, interventions dated "Approach/speak in manner." Problem: depression/sadness anxiety disorder revoluterventions revises "Offered choices to whenever possible, as ordered." Resider revised after the 1/9 incident with Resider in Resident #140's of part, "Change in con Resident being reported in the part of the p	I 1/1/19, for Resident #140 Problem: "Cognitive loss revised 6/15/18." The Goal mented, "Will display se to situation." The 4/17/17, documented, a calm, positive/reassuring "Indicators of related to depression, ised 9/3/18." The d on 5/11/19, documented, enhance sense of control Psych consult and treatment ent #140's care plan was not 1/19, resident-to-resident	F 6					
	LPN #11 stated, "It of someone, sexual or resident, hitting and considered abuse, I abuse." When ask follows regarding re #11 stated, "You se	can be physically hitting verbal." When asked if a						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01	/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	completes paperwork the care plan." An interview was cor (administrative staff inursing, on 1/16/20 atime frame for report ASM #2 stated, "It is did not report this FR I don't know what else An interview was cor AM with ASM #1, the the time frame to rep ASM #1 stated, "I kn it states in this policy time of this FRI. ASM #1, the administ corporate representate above concerns on 1 No further information References: (1) Barron's Dictional Non-Medical Reader Chapman, page 154 (2) Barron Dictional edition, Rothenberg (3) (3) Barron's Dictional	inducted with ASM member) #2, the director of at 11:20 AM, regarding the ing allegations of abuse. It wo hours. I know that we sell within the regulated period. The inguited on 1/16/20 at 11:28 administrator, when asked forting allegations of abuse, low we have two hour rule as that was in effect 1/9/19, the littrator, and ASM) #3, the	F 6	09		
F 622 SS=D	Transfer and Dischar CFR(s): 483.15(c)(1) §483.15(c) Transfer §483.15(c)(1) Facility	rge Requirements (i)(ii)(2)(i)-(iii) and discharge-	F 6:	22		2/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		Q	1/16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 622	(A) The transfer or diresident's welfare an cannot be met in the (B) The transfer or dibecause the resident sufficiently so the reservices provided by (C) The safety of indendangered due to the status of the resident (D) The health of indotherwise be endang (E) The resident has appropriate notice, to under Medicare or M. Nonpayment applies submit the necessary payment or after the Medicare or Medicairesident refuses to president who become admission to a facility resident only allowabor (F) The facility cease (ii) The facility may nesident while the ap § 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the residiacility. The facility in	and not transfer or int from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate t's health has improved sident no longer needs the the facility; ividuals in the facility is ne clinical or behavioral t; ividuals in the facility would dered; failed, after reasonable and to pay for (or to have paid edicaid) a stay at the facility. if the resident does not ty paperwork for third party third party, including d, denies the claim and the ay for his or her stay. For a les eligible for Medicaid after ty, the facility may charge a lee charges under Medicaid;	F 62	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		0	1/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	resident under any or in paragraphs (c)(1)(section, the facility mor discharge is docur medical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of parasection, the specific robe met, facility attern needs, and the service facility to meet the needs, and the service facility the n	nentation. Insters or discharges a If the circumstances specified In the circumstances specified In the resident's Instrumented in the resident record It ransfer per paragraph (c)(1) Instrumented in the resident resident resident need(s) that cannot puts to meet the resident receiving red(s). In required by paragraph (c) Instrumented by paragraph (c) Instrumented in transfer or required by paragraph (c) (1) Instrumented in the receiving red in the resident reare of the receiving provider receiving provider receiving red to the receiving provider receiving of the following: In the resident resident receiving provider receiving receiv	F 62			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED	
		495227	B. WING		0	1/16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622		.21(c)(2) as applicable, and ation, as applicable, to ensure	F 62	22		
	This REQUIREMENT by: Based on clinical redocumentation revier facility staff failed to documentation was phospital for two of 60 sample, (Residents a staff failed to ensure comprehensive care resident for a facility hospital on 1/5/2020 evidence that the approvided to the receif facility-initiated trans 11/19/2019. The findings included 1. Resident #70 was 11/30/2019. Diagnost limited to stroke, pne Resident #70's most (MDS) assessment was	cord review, facility w, and staff interview, the evidence the required provided to the receiving residents in the survey #70 and #73). The facility a copy of Resident #70's plan goals was sent with the initiated transfer to the . The facility staff failed to propriate paperwork was ving provider for a fer of Resident #73 on		F622 Transfer and Discharge Requirements 1) Corrective Action for those refound to be affected by the alleg deficient practice. Facility will predocumentation in Resident meet that appropriate information is sereceiving Hospital including Comprehensive Care Plan Goa 2) Corrective Actions taken for rewith potential to be affected by deficient practice. Residents with facility and those admitted to fact the potential to be affected. The of Nursing or designee will com audit on current residents that a transferred to Hospital have documentation that transfer for completed and comprehensive goals were sent with resident. 3) Systemic Changes put into pensure the alleged deficient pranot reoccur. The Director of Nur	ged rovide dical record sent to lls. residents alleged thin the cility have e Director plete an are m care plan blace to actice does	
	(ARD) of 12/07/2019 Mental Status (BIMS 11, indicating mild to impairment. Residen extensive assistance Activities of Daily Liv Review of the clinica Resident #70 was he the afternoon of 01/1	. The Brief Interview for) scored Resident #70 at an moderate cognitive t #70 was coded as requiring of one person for most		designee will in-service the Lice nurses on procedure for information required including transfer form comprehensive care plan goals with resident to hospital with distriction documentation with information including transfer form and comprehensive care plan goals 4) Monitoring of corrective action ensure the alleged deficient pranot recur. The Director of Nursing	ensed ation and to be sent scharge sent on to actice does	

	A. BUILDII	NG _		(X3) DATE SURVEY COMPLETED	
495227	B. WING _			01/	16/2020
	·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ING CENTER					
T OF DEFICIENCIES	ID	Kı	<u> </u>		(X5)
BE PRECEDED BY FULL	I	X	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE
	F 6	622			
ent at the time of the spital on 1/05/2020. 20, facility staff the conference table the conference table at all required items at Party, the Hospital, at for the als. ., Administrative Staff durse, confirmed that evidence to support in goals had been thospital. ., an interview was durse (RN) #3. RN #3 rocess staff follows to book for transfer to the achecklist on the wall clist". Upon review, any reference to the are plan goals. When a plan goals are sent ital, RN #3 stated, I don't know why it's (ASM) #1, the the Director of the findings at the end to the facility with the were not limited to:		522	have discharge documentation information was sent with resident to hospital including transfer form and comprehensive care plan goals x 4 weeks and monthly x 3 months .The audits will be reviewed in the quality		
	e documentation of ent at the time of the spital on 1/05/2020. 20, facility staff the conference table nat all required items e Party, the Hospital, of for the bals. , Administrative Staff Nurse, confirmed that evidence to support in goals had been hospital. , an interview was Nurse (RN) #3. RN #3 rocess staff follows to ork for transfer to the a checklist on the wall klist". Upon review, any reference to the are plan goals. When e plan goals are sent of the plan goal	B. WING_ SING CENTER TOF DEFICIENCIES BE PRECEDED BY FULL ITIFYING INFORMATION) F of december of the spital on 1/05/2020. 20, facility staff the conference table nat all required items are Party, the Hospital, of for the bals. I., Administrative Staff Nurse, confirmed that evidence to support in goals had been hospital. I., an interview was Nurse (RN) #3. RN #3 rocess staff follows to ork for transfer to the a checklist on the wall klist". Upon review, any reference to the are plan goals. When a plan goals are sent bital, RN #3 stated, I don't know why it's I (ASM) #1, the the Director of the findings at the end 20. No further directly the state of the findings at the end 20. No further directly the state of the similar with the were not limited to:	A95227 B. WING TOF DEFICIENCIES BE PRECEDED BY FULL LITIFYING INFORMATION) F 622 e documentation of ent at the time of the spital on 1/05/2020. 20, facility staff the conference table nat all required items e Party, the Hospital, of for the bals. , Administrative Staff Nurse, confirmed that evidence to support in goals had been hospital. , an interview was Nurse (RN) #3. RN #3 rocess staff follows to ork for transfer to the achecklist on the wall klist". Upon review, any reference to the are plan goals. When e plan goals are sent of a plan goals are sen	SING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE T300 FOREST AVE RICHMOND, VA 23226 TOF DEFICIENCIES DEFECT AVE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BIT TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE T300 FOREST AVE RICHMOND, VA 23226

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETION
F 622	set], a significant ch. ARD (assessment recoded Resident # 73 interview for mental - 15, 13 - being cogr decisions. The nurse's note for 11/19/2019 docume and oriented] x3 [tim	trecent MDS [minimum data ange assessment with an eference date) of 12/08/19, 8 as scoring a 13 on the brief status (BIMS) of a score of 0 nitively intact for making daily Resident # 73 dated anted, "Resident is A&O [alert less three] and able to make	F 62	2	
	asked. Resident is [congestive heart faither to gain her stren B&B [bowel and black increasing. NP [nur MD [medical doctor] this time to the ER [and talked to the da	lo complaints of pain when her [sic] r/t [related to] CHF lure], therapy is working with gth back. She is continent of dder]. Resident weight was see practitioner] notified the and resident was sent out at emergency room]. NP called ughter. No complaints of pain ss from resident when she ulance."			
	the paper clinical recto evidence docume information of the procare of Resident #73 receiving hospital at 11/19/2019. Further failed to evidence th (RP) information incinformation, Advance Resident #73, all sporecautions for ongo Resident #73's computer provided to the	e Directive information for			

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _		0	1/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	conducted with ASM member] # 3, regional After reviewing the not dated 11/19/2019, ASI documentation of what was sent to the receive 73's transfer to the horological of the conducted with RN [mass asked to describ when transferring a mass asked that the state that lists each item the where the items is to a written notice to the the RP is not in the buthe written notice by asked if the resident's included in the items stated yes, the care presidents to the hosp verifies that all require assembled for transfestated that typically the form of the theory would audit that in the event that hours, the shift super were ready. On 01/16/2020 at applications of the conduction o	14 a.m., an interview was [administrative staff all director of clinical services. Itrse's note for Resident # 73 mm # 3 stated there was no at paperwork/information ving facility upon Resident # pspital on 11/19/2019. 06 AM, an interview was registered nurse] # 3. RN # 3 re the process staff follows resident to the hospital. RN mm # 1 mm # 1 mm # 2 mm # 2 mm # 3	F 6	22		
F 656		n was provided prior to exit. Comprehensive Care Plan	F 6	56		2/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From pag	ge 70	F 6	56		
SS=E	CFR(s): 483.21(b)(1)				
	implement a compre care plan for each re resident rights set for §483.10(c)(3), that i objectives and timef medical, nursing, ar needs that are ident assessment. The codescribe the followir (i) The services that or maintain the resident and the	acility must develop and ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's id mental and psychosocial iffied in the comprehensive imprehensive care plan must ing - are to be furnished to attain dent's highest practicable dipsychosocial well-being as 8.24, §483.25 or §483.40; and it would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 3.10(c)(6). Services or specialized es the nursing facility will of PASARR if a facility disagrees with the ARR, it must indicate its lent's medical record. If the resident and the ative(s)-boals for admission and reference and potential for cilities must document it's desire to return to the essed and any referrals to es and/or other appropriate				

AND BLAN OF CORRECTION INDESTRUCTION NUMBERS		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01110/2020
WESTROE	T DELIA DIL ITATIONI A N	D MUDOING CENTED		7300 FOREST AVE	
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 656	Continued From pag	e 71	F 650	3	
	plan, as appropriate, requirements set fort section. This REQUIREMEN by: Based on resident in clinical record review	in the comprehensive care in accordance with the h in paragraph (c) of this I is not met as evidenced atterview, staff interview and it was determined that the		F656 Develop/Implement Comprehe	
	in the survey sample 135 and # 144). The implement the compleuse of non-pharmaco	plan for four of 60 residents , (Residents # 64, # 53, #		Corrective Action for those reside found to be affected by the alleged deficient practice. Resident #53 and have been discharged. Resident #13 #144 care plans have been updated. Corrective Actions taken for resident.	#64 85 and
	failed to implement F			with potential to be affected by allege deficient practice. Residents within the facility and those admitted to facility	ed ne
	The findings include:			the potential to be affected. The Dire of Nursing or designee will complete audit on current resident spain care	ector an
	diagnoses that include specified joint disorder	s admitted to the facility with led but were not limited to: er, unspecified hip, and avity [inside the nose].		to evaluate for non-pharmacological interventions and review (electronic medication record) EMAR for administration of prn pain medicatior pain level rating is administered to the	ns per
	set), an admission as (assessment referen Resident # 64 as socinterview for mental s - 15, 12 - being cogn decisions. Resident extensive assistance activities of daily livin Conditions" coded R frequent pain with a p	recent MDS (minimum data assessment with an ARD ce date) of 12/02/19, coded oring a 12 on the brief status (BIMS) of a score of 0 itively intact for making daily # 64 was coded as requiring of one staff member for g. Section J "Health esident # 64 as having pain level of four on a scale in being the worse pain.		pain level parameter per physician o 3) Systemic Changes put into place ensure the alleged deficient practice not reoccur. Inservice by the Director of Nursing of designee will be completed by the Licensed nursing on procedures for non-pharmacological intervention on pain care plan and administration of pain medications per pain level rating administered to the pain level parameter physician order.	rder. e to does or the prn g is

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	e) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01	/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	"Oxycodone Tablet 50 0.5 mg by mouth ever severe pain. Give ½ 2.5mg. Order Date: The comprehensive of dated 12/05/2019 documented, "Implementated: 12/05/2019. documented, "Implemented for effectiven 11/26/2019." Resident # 64's eMAI administration record documented the physeeMAR also documented the physeeMAR also documented the physeeMAR also documented interventions. Further every evidence documentation interventions. Further revealed the administration at 12/01/19 at 8:43 p.m. 12/05/19 at 8:37 p.m. 12/06/19 at 9:30 p.m. 12/16/19 at 2:37 p.m. 12/17/19 at 2:37 p.m. 12/19/19 at 9:22 p.m. 12/22/19 at 12:39 p.m. 12/22/19 at 12:39 p.m. 12/22/19 at 12:39 p.m.	s order sheet] dated ent # 64 documented, MG [five milligrams]. Give ry 12 hours as needed for [half] of 5mg tablet to equal 11/30/2019." care plan for Resident # 64 cumented, "Focus: Pain to onic left hip pain. Date " Under "Interventions" it nent nondrug therapies such vities, to assist with pain and ess. Date Initiated: R [electronic medication] dated December 2019 sician's order as above. The ted, "Pain Score every shift; ee, four] = Mild Pain; 5, 6, 7 oderate Pain; 8,9,10 [eight, ain." The eMAR failed to tion of non-pharmacological r review of the eMAR tration of Oxycodone on the	F 6	4) ensunot r Audi designevali inter med adm pain pain wee mon qual impr and	Monitoring of corrective action to the the alleged deficient practice recur. Its by the Director of Nursing or gnee on resident spain care plauate for non-pharmacological rentions and review (electronic lication record) EMAR for inistration of prn pain medication level rating is administered to the level parameter per physician of ekly x 4 weeks and then monthly iths. The audits will be reviewed if ity assurance and performance revement process for tracking/tre revisions as needed. Date of compliance- 2/17/2020	s per e der. x 3 n the	
	12/29/19 at 9:23 p.m.	a pain level of four. with a pain level of three. with a pain level of four. with a pain level of three.					

Facility ID: VA0270

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING	 	0.	1/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 73	F 65	56		
	administration recondocumented the phemAR also documented the phemAR also documented the phemAR also documented the phemAR also documented the phemark and on the description of the phemark and on the phemark and on the phemark and the	m. with a pain level of three. o.m. with a pain level of two. m. with a pain level of four. m. with a pain level of three. m. with a pain level of three. m. with a pain level of four. e's notes dated 12/01/2019 of failed to evidence on-pharmacological 1 p.m., an interview was sident # 64. When asked if the viate her pain before				
	medication, Reside On 01/15/20 at 2:00 conducted with LPI unit manager. Whe purpose of a care p identify the residen meet the needs and meet the resident' if the statement "Imp	s needed oxycodone pain and # 64 stated, "No." 2 p.m., an interview was N [licensed practical nurse] # 4 en asked to describe the plan, LPN # 4 stated, "To t's needs and the goals to d interventions in place to help needs." LPN # 4 was asked if lement nondrug therapies ng, activities, to assist with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		0	1/16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 656	"Interventions", on R implied the use of no interventions. LPN # reviewed the eMARs oxycodone to Reside times listed above at 12/01/2019 through 64's comprehensive was asked if the care implemented for the interventions. LPN # show." On 01/15/2020 at ap [administrative staff]	effectiveness" under esident # 64's care plan on-pharmacological 4 stated yes. LPN # 4 of for the administration of ent # 64 for the dates and the nurse's notes dated 01/15/2020 and Resident # care plan for pain. LPN #4 of plan was being use of non-pharmacological et 4 stated, "Not that we can proximately 5:40 p.m. ASM	F 65	56		
	made aware of the fill No further information References: [1] Oxycodone is use severe pain. This interest that website: https://medlineplus.gtml. 2. Resident # 53 wadiagnoses that include osteoarthritis [2], ost polyneuropathy [4]. Resident # 53's mos set), an admission a (assessment reference coded Resident # 53 assessment for men	ndings. n was provided prior to exit. ed to relieve moderate to formation was obtained from ov/druginfo/meds/a682132.h s admitted to the facility with ded but were not limited to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/	16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER	,	7300 FC	ADDRESS, CITY, STATE, ZIP CODE DREST AVE IOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 75 dent # 53 was coded as	F 6	556			
	requiring extensive as member for activities	ssistance of one staff of daily living. Section J oded Resident # 53 as					
	"Acetaminophen Tabl 2 [two] tablet by mou	s order sheet] dated ent # 53 documented, let 325MG [milligrams]. Give th every 6 [six] hours as Order Date: 11/21/2019."					
	administration record documented the physical eMAR also document 1,2,3,4 [one, two, three [five, six, seven] = Monine, ten] = Severe Pevidence documentation	R [electronic medication] dated November 2019 sician order above. The ted, "Pain Score every shift; ee, four] = Mild Pain; 5, 6, 7 oderate Pain; 8,9,10 [eight, rain." The eMAR failed to tion of non-pharmacological er review of the eMAR					
	the dates and times at 11/23/19 at 12:51 p.m and at 8:22 p.m. with 11/25/19 at 4:48 p.m. 11/26/19 at 12:37 a.m and at 8:47 p.m. with	n. with a pain level of three a pain level of three. with a pain level of four. n. with a pain level of four					
	Review of the nurse's through 11/30/2019 fadocumentation of nor interventions.						
	conducted with Residual staff attempt to allevia	o.m., an interview was dent # 53. When asked if the ate the pain before needed pain medication					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			1/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	conducted with LPN unit manager. Wher purpose of a care plaidentify the resident's meet the needs and meet the resident' not the statement "Implesuch as repositioning pain and monitor for "Interventions", on Rimplied the use of not interventions. LPN # reviewed the eMAR Acetaminophen to Rand times listed about dated 11/23/2019 the Resident # 53's compain. LPN #4 was the was being implement non-pharmacological stated, "Not that we on 01/15/2020 at application, and interventions. LPN #4 was the was being implement non-pharmacological stated, "Not that we on 01/15/2020 at application, ASM #4 made aware of the fill No further information. References: [1] Used to relieve meadaches, muscles and reactions to vacoreduce fever. Acetar	p.m., an interview was [licensed practical nurse] # 4 a asked to describe the an, LPN # 4 stated, "To a needs and the goals to interventions in place to help eds." LPN # 4 was asked if ment nondrug therapies g, activities, to assist with effectiveness" under esident # 53's care plan on-pharmacological 4 stated yes. LPN # 4 for the administration of esident # 53 for the dates we and the nurse's notes rough 11/30/2019 and prehensive care plan for the need of the care plan ted for the use of a interventions. LPN # 4 can show."	F 6	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/	16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 656	joints). Acetaminoph medications called a antipyretics (fever rethe way the body set body. This informat website: https://medlineplus.gtml. [2] The most common pain, swelling, and retrained from the https://medlineplus.gtml. [3] Makes your bone break. This informat website: https://www.nlm.nih.s.html. [4] Poly meaning mathrips://www.merrianed.	acdown of the lining of the men is in a class of analgesics (pain relievers) and educers). It works by changing enses pain and by cooling the ion was obtained from the gov/druginfo/meds/a681004.h on form of arthritis. It causes reduced motion in your joints. Doint, but usually it affects your or spine. This information	F	356				
	spinal cord to the re neuropathy means t properly. Periphera because of damage of nerves. It may als body. This informat website: https://medlineplus.g	carry signals to and from the st of the body. Peripheral hese nerves don't work I neuropathy may occur to a single nerve or a group to affect nerves in the whole ion was obtained from the gov/ency/article/000593.htm. as admitted to the facility on agnoses of but not limited to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		,	01/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 656	stage renal disease, osteoporosis, pressu hyperparathyroidism dialysis dependent, osyndrome, pituitary rorthostatic tachycard 3rd degree burn. The Data Set) with an AFDate) of 12/29/19 cocognitively intact in a decisions. The residextensive care for bambulation out of the bed; limited assistant ambulation in the roof or eating; and was fowel and bladder. A review of the compresident #135 reveat documented, "Pain rowell Neuropathy, wound, included the interver documented, "Implemas activities, position assist with pain and A review of the clinical following physician's - 12/23/19 for "Aceta MG (milligrams) Give as needed for pain." - 12/23/19 for "Diclo Apply 2 gram transdrib pain four times a	neurogenic bladder, are ulcers, hypothermia, convulsions, arthritis, diabetic retinopathy, dumping micro adenoma, postural dia syndrome, and history of the Admission MDS (Minimum RD (Assessment Reference ded the resident as being ability to make daily life lent was coded as requiring athing, toileting, dressing, the room and transfers out of the foreign and hygiene; supervision requently incontinent of the leated to arthritis, rib pain." This care plan for alled one dated 12/24/19 that the lated to arthritis, rib pain. This care plan for alled one dated 12/24/19, ment nondrug therapies such a ling, ice/heat as indicated to monitor for effectiveness." all record revealed the orders: aminophen (1) Tablet, 325 to 2 tablet orally every 6 hours fenac (2) Sodium Gel 1% the ermally as needed for right day."	F 65	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From page	e 79	F 6	56			
	-	administered on 12/24/19, 2/27/19, and 12/31/19.					
	that the Diclofenac S	mber 2019 MAR revealed odium Gel 1% was applied 19, 12/25/19, 12/27/19, and					
	reveal any document	clinical record, failed to ed evidence of interventions, being offered					
	with LPN #8. When a staff follows for a res LPN #8 stated, "Ask of the pain, aggravati worse or better, offer (non-pharmacological check the medication PRN. If it is a trend, something different.	M, in an interview conducted asked about the procedure ident complaining of pain, for a number (0-10), intensitying factors, what makes it non-pharmacological's all interventions) first, then a list to see what they have mention it to the doctor for Document the . Document pre and post					
	with LPN #9, the unit don't see anything at the notes." When as care plan for Resider providing non-pharm	M, in an interview conducted manager, LPN #9 stated, "I cout non-pharmacological in ked if the comprehensive at #135 was followed for acological interventions for "I can't say that it was					
	Comprehensive Pers	y policy, "Care Plans, con-Centered" documented, erson-centered care plan able objectives and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			01/16/2020		
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 656	psychosocial and fur and implemented for the most recent MD assessment, an administrative staff.	ne residents' physical, nctional needs is developed reach resident." Eximately 1:40 PM, ASM #1 Member, the Administrator), or of Nursing), ASM #3 (the ad ASM #4 (the Medical eraware of the findings. No was provided by the end of the distribution	F 6	56				
	cognitive decisions.	ly impaired to make daily Resident #144 was coded as assistance for all of her						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/	16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	∍ 81	F 6	656			
		g. In Section J - Health nt was coded as having no					
	documented in part, 'fractures." The "Interpart, "Administer pair orders. Implement no	care plan dated, 12/30/19 "Focus: Pain related to ventions" documented in medications per physician ondrug therapies such as es, to assist with pain and ess.					
	treat mild to moderate (milligram); Give 2 tal as needed for Mild Pa to treat moderate to s	ninophen (Tylenol) (used to e pain) (1) tablet 325 MG blet by mouth every 6 hours ain. Oxycodone tablet (used severe pain) (2) 5 MG; give 1 of 6 hours as needed for mod					
	every shift: 0 = No pa	MAR (medication) documented a "Pain Score in; 1, 2, 3, 4 = Mild Pain; 5, 8, 9, 10 = severe pain."					
	documented on the D December, the reside Tylenol on the followi scale ratings as follow 12/28/19 at 5:16 p.m. 12/29/19 at 8:05 a.m. 12/31/19 at 5:35 a.m. The December 2019	 pain level = 3 pain level = 5 pain level = 6 MAR documented the inistered on the following pain scale: pain level = 2 					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			01/16/2020		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 656	Continued From page	ge 82	F 6	56				
	physician medicatio documented as hav Oxycodone was doc administered on the pain scale ratings at 1/2/2020 at 6:38 a.m. 1/4/2020 at 6:38 a.m. 1/5/2020 at 6:47 p.m. 1/5/2020 at 3:35 p.m. 1/9/2020 at 6:00 p.m. 1/10/2020 at 7:17 p.m. 1/11/2020 at 5:54 p.m. 1/12/2020 at 6:15 a.m. 1/12/2020 at 8:41 a.m. Of these ten doses per the physician or Review of the nurse and dates in Decembral at 1/12/2020 at 3:10 p.m. 1/13/2020 at 8:41 a.m. Of these ten doses per the physician or Review of the nurse and dates in Decembral at 1/12/2020 at 3:10 p.m. 1/13/2020 at 3:41 a.m. Of these ten doses per the physician or Review of the nurse and dates in Decembral at 1/12/2020 at 3:41 a.m. 1/13/2020 at 3:4	cumented as being following dates, times for s follows: n pain level 4 n pain level 3 n pain level 6 n pain level 6 n pain level 6 m pain level 5 m pain level 5 m pain level 6 administered, only four were der for moderate pain. 's notes for the above times aber 2019 and January 2020 any non-pharmacological ed prior to the administration						
	nurse) #6, the qualit manager, on 1/16/2 care plan document ordered, and to try r the administration o notes and MAR with non-pharmacologica physician ordered p severe pain and the the pain ratings, we When asked if the s	inducted with RN (registered by assurance nurse/unit 020 at 9:00 a.m. The resident ing to give medications as non-drug interventions prior to f medication, the nurse's nout documentation of all interventions and the arameter of moderate to oxycodone administered with re reviewed with RN #4. taff were implementing the e plan and administering pain						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/	16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657 SS=E	stated, "No." Administrative staff madministrator and AS were made aware of 1/16/2020 at 1:05 p.m. No further information of following website: https://medlineplus.gottml (2) This information of following website: https://wsearch.nlm.nimeta?v%3Aproject=rmedlineplus-bundle&Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A complete (i) Developed within the comprehensive a (ii) Prepared by an inincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food	nember (ASM) #1, the M #3, the corporate nurse, the above concern on n. In was provided prior to exit. In was obtained from the ov/druginfo/meds/a681004.h It was obtained from the ov/drugi		656			2/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	DDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	An explanation must medical record if the and their resident report of practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii) Reviewed and reviteam after each assessments. This REQUIREMENT by: Based on staff intervand clinical record rethe facility staff failed comprehensive care residents in the surver Resident #140, Resident #140, Resident #140, Resident #140 to incident of Resident #140 to incident of Resident #140 to incident of Resident #140 to incident with the comprehensive care Resident #22 after Resident #22 after Resident #22 after Resident #25 include: 1. Resident #462's more and Resident #462's more r	resident's representative(s). be included in a resident's participation of the resident bresentative is determined de development of the estaff or professionals in ined by the resident's needs are resident. Fised by the interdisciplinary resement, including both the quarterly review If is not met as evidenced Fiew, facility document review review, it was determined that to review and revise the plan for four of sixty review and revise are plans for Resident failed to review and revise are plans for Resident # 462 to address a witnessed abuse #140 striking the left slide of to, on 1/9/2020. The facility and revise the plans for Resident #712 and resident #22 struck Resident with a Reacher on 2/27/2019.	F 6	F657 Care Plan Timing and R 1) Corrective Action for those of found to be affected by the alled deficient practice. Resident □s #712 have been discharged. F #22 and #140 care plans have revised. 2) Corrective Actions taken for with potential to be affected by deficient practice. Residents we facility have the potential to be The Director of Nursing or descomplete an audit on current rechange of condition, incident reinvolve one or more residents plan revisions completed. 3) Systemic Changes put into ensure the alleged deficient prot recur. Inservice by the Director of Nursing or designee to Licens on revising care plans at the times.	residents eged #462 and Residents been residents abeen residents alleged within the affected signee will esidents eports that have care place to ractice does ector of ed nurses me of		
	with an ARD (assess	t, a quarterly assessment, ment reference date) of resident as scoring a 7 out of		change of condition or inciden involve change of condition, in than one resident must have conditions.	jury or more		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/	16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	score, indicating the rintact. indicating the rintact. indicating the rintact. indicating the rimpaired cognition. A G-functional status or requiring extensive as locomotion on/off the personal hygiene and eating. A FRI (Facility Report documented in part, "12:46 PM. Resident and (Resident #140). resident altercation. Incident: Resident #4 chair in hallway. Res #462 on the left side of Resident #462 was a 7/20/17 with diagnose limited to: dementia (decline) (1), COPD (depulmonary disease a (2), Schizoaffective dicharacterized by distordisturbances of though The care plan for Resident part, Fagitation/aggression in The Interventions dat "Remove from public disruptive/unacceptate with all activities." Renot revised after 1/9/1 above.	interview for mental status) resident was cognitively resident had severely review of the MDS Section oded the resident as resistance for bed mobility, unit, dressing, toilet use, requiring supervision in red Incident) dated, 1/9/19, Incident date: 1/9/19, time: resinvolved (Resident #462) Incident type: resident on injuries: "No." Describe resident #140 slapped Resident refine the face." dmitted to the facility on rest that included but were not reprogressive state of mental rehronic obstructive ron-reversible lung disease) resorder (mental disorder retions of reality, relicity) related to cognitive loss." red 1/1/19, documented, related to cognitive loss." red 1/1/19, documented, related to resident #462's care plan was related to resident #462's related to Resident #462's	F	657	revisions for each resident. 4) Monitoring of corrective action to ensure the alleged deficient practice do not reoccur The Director of Nursing or designee will complete an audit of the 2 hour report to review revision of care plans for change of condition were completed and review incidents reports that involves change of condition, injury more than one resident had care plan revised on each resident weekly x 4 weeks and then monthly x 3 months. Taudits will be reviewed in the quality assurance and performance improvem process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	24 6 7 or he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	•	711716/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 657	Continued From pag		F 6	57		
	related to Resident b	"Change in condition noted being slapped on the left side er resident. No injury noted aplaints of pain. Skin color is				
	PM with LPN (licens regarding the proces resident-to-resident separate the resider inform manager. The	nducted on 1/14/20 at 4:35 ed practical nurse) #11, es staff follows for abuse. LPN #11 stated, "You ets, calm them down and e manager completes ing and updates the care				
	nurse) #7, the staff of 1/15/20 at 8:29 AM. education regarding plans, RN #7 provide 2020 with topics out documentation educorientation. When a comprehensive care	sked about the purpose of plans, RN #7 stated, "Care are for the resident." When ates in care plan				
	nursing, on 1/16/20 a AM. When asked th a resident on resider "Residents are sepa injury. Reporting for The physician/nurse (responsible party) a statements are obtain	member) #2, the director of at 11:20 AM1/16/20 at 11:20 e procedure staff follows for at altercation, ASM #2 stated, rated and assessed for ms are completed and faxed.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED	
		495227	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	stated, "It is to deve specific care of the plan for Resident # to reflect the 1/9/20 "Yes, it should have ASM #1, the admin corporate represen above concerns on No further information References: (1) Barron's Diction Non-Medical Reade Chapman, page 15 (2) Barron Diction edition, Rothenberg (3) Barron's Diction Non-Medical Reade Chapman, page 51 2. Resident #140 w 4/10/17 with diagnor limited to: demention decline) (1), anxiety apprehension and find depression (feeling or hopelessness) (3) The most recent Mi assessment (after the assessment, with a date) of 2/14/19, conduction and 15 on the mental status) scorn severely impaired of Section G-functions.	prehensive care plan, ASM #2 plop plans needed for the resident." When asked if care 462 should have been revised 20 incident, ASM #2 stated, been revised." istrator, and ASM) #3, the tative were made aware of the 1/15/20 at 5:05 PM. If the dition, Rothenberg and 4. It the dition, Rothenberg and 4. It the dition, Rothenberg and 4. It the dition, Rothenberg and 5. It the dition, Rothenberg and 6. It the dition, Rothenberg and 7. It the dition, Rothenberg and 8. It the dition are the facility on the dition and the facility on the disorder (mild to severe feelings of panic) (2), It the disorder of the facility on the facility on the disorder (mild to severe feelings of panic) (2), It the disorder of the facility on the facility	F	657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		0	1/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO. 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657		toilet use, personal hygiene	F 6	57			
	room, locomotion on	ision in transfer, walking in /off unit and eating. ted Incident) dated, 1/9/19,					
	documented in part, 12:46 PM. Resident and (Resident #462) resident altercation. Incident: Resident #4 chair in hallway. Res	"Incident date: 1/9/19, time: t's involved (Resident #140) . Incident type: resident on Injuries: "No." Describe 162 was sitting in her wheel sident #140 slapped Resident of the face." The alleged					
	documented in part, related to Dementia I dated 7/31/19 docum appropriate response Interventions dated 4 "Approach/speak in a manner." Problem: "	e to situation." The l/17/17, documented, a calm, positive/reassuring					
	anxiety disorder revised Interventions revised "Offered choices to e whenever possible. as ordered." Reside	sed 9/3/18." The 5/11/19, documented, hhance sense of control Psych consult and treatment ht #140's care plan was not 19, resident-to-resident					
	in Resident #140's cl part, "Change in con- Resident being repor- resident. This change 1/9/19. Since this standard Both residents were	ote dated, 1/9/19 at 1:24 PM, inical record documented in dition noted related to ted to have hit another le in condition started on arted, it has gotten better. separated and situation ssessed no injuries or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/	16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER	1	7300 I	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE MOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	e 89	F 6	57				
	distress. Resident of accepted."	fered divisional activities and						
	PM with LPN (license When asked about the resident-to-resident as "You separate the resinform manager. The paperwork for reporting plan."	ducted on 1/14/20 at 4:35 ad practical nurse) #11. ae procedure staff follows for altercations, LPN #11 stated, sidents, calm them down and a manager completes and and updates the care ducted with RN (registered						
	nurse) #7, the staff do 1/15/20 at 8:29 AM. education regarding of plans, RN #7 provide	evelopment coordinator, on When asked about staff documentation and care d an education calendar for ned and stated care plan						
	comprehensive care							
	nursing, on 1/16/20 a AM. When asked the a resident on residen "Residents are separ injury. Reporting form The physician/nurse (responsible party) ar statements are obtain /care plan is revised.' purpose of the comprestated, "It is to development on the state of the compression	nember) #2, the director of t 11:20 AM1/16/20 at 11:20 e procedure staff follows for t altercation, ASM #2 stated, ated and assessed for ns are completed and faxed. practitioner and RP						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	To reflect the 1/9/20: "Yes, it should have ASM #1, the adminicorporate represent above concerns on No further information. References: (1) Barron's Dictionation. Non-Medical Reade Chapman, page 15-	140 should have been revised 20 incident, ASM #2 stated, been revised." Instrator, and ASM) #3, the stative were made aware of the 1/15/20 at 5:05 PM. In the same provided prior to exit. Instrator, and ASM) #3, the stative were made aware of the 1/15/20 at 5:05 PM. In the same provided prior to exit.	F 6	57		
	edition, Rothenberg (3) Barron's Dictions Non-Medical Reade Chapman, page 15 3. Resident #712, of the facility, was adm with the diagnoses cerebrovascular dis hemiplegia, aphasia unspecified hand, d intracranial hemorr subarachnoid hemo communication defi (Minimum Data Set (Assessment Refere the resident as bein daily decision-makin as requiring total ca extensive care for b hygiene; supervision incontinent of bowe A review of the facil	and Kaplan, page 42. ary of Medical Terms for the er, 7th edition, Rothenberg and 7 who was no longer residing in nitted to the facility on 5/4/17 of but not limited to ease, convulsions, a, dysphagia, contracture of epression, non-traumatic nage, non-traumatic orrhage, and cognitive cit. The quarterly MDS) assessment with an ARD ence Date) of 7/25/19 coded ag moderately impaired for ng. The resident was coded re for bathing and toileting; ed mobility, dressing, and n for eating; and was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		0	1/16/2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 657	care plans are reversidents and the Review of a Facili 2/27/19 documen altercation happeresidentsReside were separated a assessed for injurthospital for furthe (Resident #22 wa 12/27/18; diagnosto high blood presidents The quawith an ARD (Ass 10/31/19 coded thimpaired in ability The resident was care for bathing; I dressing, and toile ambulation, eating continent of bower A review of the foldocumented, "On 2/27/19), approxir (Licensed Practicular and was (Resident #712). the bridge of her massist (Resident #712). started swinging residents and the resident #712).	s of residents are ongoing and vised as information about the residents' conditions change." Ity Reported Incident (FRI) dated ted, "An (sic) physical ned between two ents (Resident #22 and #712) and made safe. Both residents y. (Resident #712) sent to rassessment." It is admitted to the facility on the sincluded but are not limited assure, dementia with behaviors, ty disorder and chronic kidney arterly MDS (Minimum Data Set) to make daily life decisions. Coded as requiring extensive imited assistance for transfers, eting; supervision for g and hygiene; and was	F	657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/	/16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	from (Resident #22). assistance. (CNA #4 Assistant) and (LPN assisted with leading room. During this tir (Resident #22) said down." Medical care #712) and then sent primarily evaluate he #712) was complaint showed signs such a areas, skin tear, which from being struck mathat were witnessed transferred back to uno broken bones. To they arrived before (transferred to ER. (Inot decided if he will (Resident #22) and (roommates. It has be (Resident #712) was aggression." A review of the incid worker note dated 20. "Informed by staff the roommate and recein hematoma. In to see roommate was phys Prior to conversation separated and put in calm during convers anticipating being see Provided support an indicated she was not seed to the serior of the support an indicated she was not seed to the serior of the support an indicated she was not seed to the serior of the support an indicated she was not seed to the serior of th	n and secure the reacher LPN called out for 2) (Certified Nursing #1) bot (sic) responded and g (Resident #22) out of the me period of being separated "I told her to turn her TV was given to (Resident to ER (emergency room) to er hand which (Resident ing of pain. (Resident #712) as redness of skin in multiple ch can be assumed to be any times beyond the 4-5 hits (Resident #712) was is in the same evening with the police were notified and Resident #712) was Resident #712) husband has be pressing charges. Resident #712) are no longer teen substantiated the (sic) to the victim of (Resident #22) Teent report revealed a social f27/19 that documented, at resident was struck by	F 65	57		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495227	B. WING			01/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	emotionally. Spoke v [responsible party]) to RP that the police ha indicated that he did pressed; however, all for resident to be sen evaluation. Assured evaluated through EF with resident [#712] a calm and did not feel that counseling service group) were a managing emotions r however, resident de (counseling service g feel the need. Reside writer know should sh supportive counseling to whether or not he filed against resident' that he did not wish fo continue to assist with Further review of the line item that docume Plan (include recomn (and) new interventio care plan)Cu prevent recurrences; being made at this tin RECOMMENDATION The line for "Current marked. The line for "RECOM completed for Reside "send to ER for evaluation "Service and the did not service and to ER for evaluation "Service and the did not service and to ER for evaluation "Service and the did not service and the service and the did not service and the se	with RP (name of RP of discuss situation. Informed of been contacted. RP not wish for charges to be so indicated that he wished to the emergency room for RP that resident will be R [emergency room]. Spoke again who stated she was in danger. Advised resident cest through (counseling available to assist with elated to the incident; clined to be seen by roup), indicating she did not ent [#712] stated she will let be feel the need for g. Inquired again with RP as wished for charges to be sommate. RP re-iterated for charges to be filed. Will he needs as they arise." Incident report revealed a sented, "Response/Action mendations to physician & no the interdisciplinary rrent plan is effective to no recommendations are nee. IS:"	F 6:	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From pag	e 94	F 6	57			
	Resident #712 was r address this residen	eviewed and revised to to resident incident.					
	A review of the clinic following notes:	al record revealed the					
	related to Upon responserved resident be reacher by her room nurse attempted to sattempt, the roomma other residentSKII following skin condition Resident noted to has swelling, redness to of head, laceration to laceration x 2 w/ swelling, redness to left noted related to charonset of pain noted. at 10 on a 1-10 scaleright hand/knuckles,	"Change in condition noted onding to call bell, nurse sing struck w/ (with) a mate at bedside. As the eparate residents, w/ each te continued to strike the N: Noted to have the ons present: Laceration. Ever multiple hematomas w/ facial area, laceration to top or bridge of nose w/ swelling, selling to rt (right) hand, so, redness w/ swelling to right axilla. Evidence of PAIN ange in condition/status. New Most recent pain level noted e. c/of (complains of) pain to limited ROM (range of VNL (within normal limits) for					
	oriented x 3, no char	"Resident alert, verbal and nges in neuro [neurological] ssessment, Neuro checks					
	doctor/responsible p Administration, state agencies notified, fac Ice applied to affecte	"MD/RP/SS (medical arty/social services), and law enforcement cility investigation initiated. It areas, resident medicated thand, will monitor.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		0	1/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226			
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F 657	Continued From pag	e 95	F 6	57			
	N.O.O. (new order o for evaluation, RP av	btained) send resident to ER vare"					
	returned to facility via (2/27/19 at 11:00 PM order - Ibuprofen (1) tablets by mouth even No complaints of pai assist with ADLs (acto make needs know hand knuckles and of forehead and bride no drainage noted. I right forehead. Pt retime. Stated she just assessments initiate motion] to right hand watching television of bowel and bladder. without discomfort or during shift. HOB (h Turned and reposition. A hospital "Discharged documented, "Contu 200 Milligrams # 1 beas needed You have Contusions are area in the soft tissues. The and bleeding in the in will give you a painle contusions may stay weeks. There are not takes a few days to a supplementation of the complete of the com	orehensive care plan ntation or evidence of a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED	
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	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	EET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 657	conducted with OSI Social Worker, and Member) the Admin "They [Resident #7 a large room, and the volume of the TV are that. [Resident #22 make her turn down aggressive. She [Resident worker turn down aggressive. They did asked about the care being reviewed and OSM #4 had no information the survey. References: (1) Ibuprofen - is us and swelling. Information obtaine	AM, an interview was M #4 (Other Staff Member) the ASM #1 (Administrative Staff instrator. OSM #4 stated, 12 and Resident #22] were in here was discussion over the and a disagreement related to 1 went to the other resident to 1 went to the other resident to 1 the TV by being physically desident #712] was sent out for family was offered the with the police and press not press charges. When the plan for Resident #712 not 1 revised after the incident, formation on this.	F6	557			
	12/27/18; diagnose: to high blood pression, anxiety disease. The quart with an ARD (Asses 10/31/19 coded the impaired in ability to	as admitted to the facility on sincluded but are not limited ure, dementia with behaviors, disorder and chronic kidney erly MDS (Minimum Data Set) assment Reference Date) of resident as being mildly or make daily life decisions.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3	o) DATE SURVEY COMPLETED
		495227	B. WING _			01/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER	•	STREET ADDRESS, CITY, STATE, Z 7300 FOREST AVE RICHMOND, VA 23226	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO THE APPROPRIATE	(X5) COMPLETION DATE
F 657	dressing, and toileting ambulation, eating ar continent of bowel and A review of the facility Comprehensive Pers "13. Assessments of care plans are revise residents and the research of the test of t	ed assistance for transfers, g; supervision for and hygiene; and was and bladder. / policy, "Care Plans, on-Centered" documented, residents are ongoing and d as information about the idents' conditions change." Reported Incident (FRI) dated "An (sic) physical between two were separated and made	Fé	657		
	the facility, was admir with the diagnoses of cerebrovascular dises hemiplegia, aphasia, unspecified hand, de intracranial hemorrha subarachnoid hemorr communication defici (Minimum Data Set) of Reference Date) of 7 being moderately imp decision-making. The requiring total care for extensive care for be hygiene; supervision incontinent of bowel at	ase, convulsions, dysphagia, contracture of pression, non-traumatic ge, non-traumatic thage, and cognitive t. The quarterly MDS with an ARD (Assessment /25/19 coded the resident as paired for daily the resident was coded as r bathing and toileting; d mobility, dressing, and for eating; and was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495227	B. WING _		0	1/16/2020
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP (7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 657	(Licensed Practical nurse call system entering room, (Reher hand and was (Resident #712). The bridge of her massist (Resident #712). Started swinging restruck her 4-5 time safely separate the from (Resident #2 assistance. (CNA Assistant) and (LF assisted with lead room. During this (Resident #22) sadown." Medical call #712) and then seprimarily evaluate #712) was complast showed signs such areas, skin tear, we from being struck that were witnesse transferred back to no broken bones. They arrived before transferred to ER. not decided if he we (Resident #22) and roommates. It has (Resident #712) waggression."	age 98 nately 5:00pm, (LPN #12) al Nurse) responded to the for resident (#712). Upon esident #22) had a reacher in sitting on side of bed of (Resident #712) had blood on lose. (LPN #12) attempted to 22) off of bed and away from At this point (Resident #22) eacher at (Resident #712) and es before LPN (#12) could em and secure the reacher 2). LPN called out for #9) (Certified Nursing PN #1) bot (sic) responded and ing (Resident #22) out of the time period of being separated id "I told her to turn her TV are was given to (Resident int to ER (emergency room) to her hand which (Resident ining of pain. (Resident #712) h as redness of skin in multiple which can be assumed to be many times beyond the 4-5 hits ed. (Resident #712) was o us in the same evening with The police were notified and e (Resident #712) was (Resident #712) husband has will be pressing charges. d (Resident #712) are no longer es been substantiated the (sic) that the victim of (Resident #22) sident report revealed a social 2/27/19 was conducted. This dressed Resident #712 and not	F	357		

EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		' '	DATE SURVEY COMPLETED
	495227	B. WING _			01/16/2020
DER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
esident #22. In ther review of the eitem that document (include recomend) new interventions are plan)Cevent recurrences in grade at this tecomment of the line for "Current arked. In the line for "Current arked. In the line for "RECO impleted for Residuation." No new incumented for Residuation." No new incumented for Residuation." No new incumented for Residuation. In the line for "BECO impleted for Residuation." No new incumented for Residuation. In the line for "Current arked. In the line for "Current arked.	e incident report revealed a nented, "Response/Action amendations to physician & ions on the interdisciplinary current plan is effective to s; no recommendations are time. DNS:" It plan is effective" was not MMENDATIONS" was dent #712 to "send to ER for w interventions were sident #22, nor evidence that care plan for Resident #22 cal record revealed the "Resident [Resident #22] (new room number), RP o noted injuries to resident any injuries as a result of the staff will remain with and the duration of the night. Insult - Progress Note dated and commer roommateAn quested on an emergent basis	F 6	57		
	SUMMARY S (EACH DEFICIEN REGULATORY OF Details and include recommend) new interventing made at this to the line for "Currentarked. The line for "Currentarked. The line for "RECOMMENDATION The line for "Currentarked. The line for "RECOMMENDATION The line for "Currentarked. The line for "Currentarked.	DER OR SUPPLIER SEHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Dentinued From page 99 esident #22. Inther review of the incident report revealed a se item that documented, "Response/Action an (include recommendations to physician & and) new interventions on the interdisciplinary re plan)Current plan is effective to event recurrences; no recommendations are ing made at this time. ECOMMENDATIONS:" The line for "Current plan is effective" was not tarked. The line for "RECOMMENDATIONS" was mpleted for Resident #712 to "send to ER for aluation." No new interventions were cumented for Resident #22, nor evidence that the comprehensive care plan for Resident #22 as reviewed.	DER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Intinued From page 99 esident #22. Inther review of the incident report revealed a eritem that documented, "Response/Action an (include recommendations to physician & had) new interventions on the interdisciplinary replan)Current plan is effective to event recurrences; no recommendations are ing made at this time. ECOMMENDATIONS: " The line for "RECOMMENDATIONS" was mpleted for Resident #712 to "send to ER for aluation." No new interventions were cumented for Resident #712 to "send to ER for aluation." No new interventions were cumented for Resident #22, nor evidence that the comprehensive care plan for Resident #22 insferred to room (new room number), RP vare. There are no noted injuries to resident of the bident at this time. Staff will remain with and conitor resident for the duration of the night. Mental Health Consult - Progress Note dated 5/19 documented, "Client stated she was "doing tight" now that she does not have to be in the me room as her former roommateAn seessment was requested on an emergent basis lowing an incident in which client physically saulted her roommate with her grabberClient	DER OR SUPPLIER ### A BUILDING ### A BUILDIN	DER OR SUPPLIER ### 495227 ### 495227 ### 495227 ### A BUILDING ###

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			1/16/2020
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 657	when someone ratalked further abo "irritating" and diff herClient is cur appears to be mo at this time. She her room shut mo possibility of unple makes no promise not lash out physi "blood pressure to placed in a room would need to be passive and easy presents as some PTSD [post-traum and, as such, can defensive action, physically defendi which is not easily long-term counse change. Recomm room or, if with ro- chosen in order to Client repots that [television] but wo with word puzzles activities" A review of the co revealed no docur review or revision On 1/16/20 at 10: conducted with O Social Worker, an Member) the Adm	g that "this is what happens ises my blood pressure". She ut her former roommate being icult with staff as well as with rently in a private room which is appropriate placement for her is choosing to leave her door to st of the time to decrease easant interactions. Client es or guarantees that she will cally again if anyone causes her or rise again". If she is to be with a new roommate, she with a resident who is fairly to get along with. Client one with longstanding, chronic factic stress disorder] symptoms be easily triggered into which in her case, results in ng herself. This is a condition or remediated and would require ling services to begin to effect a finend that client remain in private formmate, one that is carefully of avoid future physical incidents. She does not watch much TV fould enjoy entertaining herself, coloring or other similar. In AM, an interview was SM #4 (Other Staff Member) the d ASM #1 (Administrative Staff inistrator. OSM #4 stated, arge room, and there was	F	357		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPL	
		495227	B. WING _			01/16/2020
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT	
F 657	disagreement relativent to the other of the TV by being pleased [Resident #712] where the police and precharges. To my knot previously dispetaviors. She [Form any type of treating to someone else. (Coame in, and an Leworker) follows here indicated she felt of from her choice of watching shows as being counseled of mood. (Resident in horror movies, etchave seen. (Count working with here roommate after so documentation by was appropriate for no demonstrated of 8/19/19 document new roommate). It contact with the severbally aggressive [Resident #22] was roommate after the else in her space of Alternative placements is sinding apanyone agreeable residents, no one	e volume of the TV and a ted to that. (Resident #22) esident to make her turn down hysically aggressive. She as sent out for an evaluation. ered the opportunity to talk with se charges. They did not press nowledge, (Resident #22) had olayed potentially aggressive tesident #22] was removed tiggers to a private room. The be having to share space with ounseling services group) CSW (licensed clinical social r. A psych (psychiatric) evaluer behaviors were stemming TV programming and she was aggressive in nature. She was no TV choices to calm her #22) watched police shows, she is better now from what I seling services group) is still She was given another	F 6	57		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	(X3) DATE COMP	SURVEY LETED
		495227	B. WING _		01/	16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658 SS=D	Medicaid resident. Sherself. She has had residents outside her residents outside her admission until the in towards other resider and treatment at time then. She has not de issues towards other room to herself, not eroom. She will remai asked about the care being reviewed and resident indecent with had no information or No further information the survey.	the is a long-term care the will remain in a room by no altercations with room. No issues with room. In the 2 months from cident, she had no behavior its. Only had resisted care s. She was docile until monstrated any behavior residents anytime she has a ven when she is outside her in in a private room." When plan for Resident #22 not evised, after the resident to in Resident #712, OSM #4 in this. In was provided by the end of eet Professional Standards	F 6			2/17/20
	as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on staff interviacility document revireview, it was determ failed to follow the propractice for three of sample, (Resident #8 Resident #139). The professional standard	d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced iew, resident interview, ew and clinical record ined that the facility staff ofessional standards of ixty residents in the survey		F658 Services Provided Meet Professional Standards 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #57 has be discharged from the facility. Resident # nurses were educated on remaining wit Resident during medication administration. Resident #139 nursing	en 81	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		495227	B. WING			01	/16/2020
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTBOR	OT DELIABILITATION AN	D NUDCING CENTED	7300 FOREST AVE		300 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NORSING CENTER		R	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 103	F	658			
	staff present and was sight of any staff. The professional standard orders for the prescri medication Oxycodor narcotic painkiller) to parameters for when medication should be #57. The facility staff standards to clarify main medication orde level parameters for a which, and when each medication should be	ne 20mg [milligram] (a determine the pain level the prescribed as needed e administered to Resident f failed to follow professional nultiple prescribed as needed rs without prescribed pain administration, to determine			staff were educated on administering I medication according to physician sorder. 2) Corrective Actions taken for resident with potential to be affected by alleged deficient practice. Residents that have nebulizers treatments and prn pain medications have the potential to be affected. The Director of Nursing or designee will complete an audit on cur residents with Jet Nebulizers orders at administered to physician orders. The EMAR (electronic medication administration record), 24-hour report documentation to review administratio prn pain medications per pain level ratis administered to the pain level parameter per physician order 3) Systemic Changes put into place to	its I jet rrent re n of ing	
	The findings include:				ensure the alleged deficient practice d not reoccur. In-services for the License	oes ed	
	11/1/17 with diagnose limited to: COPD (ch disease a non-revers fibrillation (a rapid/rar of the heart) (2), glau	admitted to the facility on es that included but were not ronic obstructive pulmonary ible lung disease) (1), atrial adom contraction of top part coma (high pressure in the division or blindness) (3).			Nurses will be completed by the Direct of Nursing or designee on procedure of nebulizer treatments will be observed the Licensed Nurse until completed, for resident to perform independently, a substitution assessment will be completed to determine if able to self-administer. The procedure for	of jet by or a	
	date) of 12/5/19, code 13 out of 15 on the B mental status) score, cognitively intact. A I G-functional status of	e event), a quarterly ARD (assessment reference ed the resident as scoring a IMS (brief interview for indicating the resident was review of the MDS Section oded the resident as for eating and limited			administration of prn pain medications pain level rating is administered to the pain level parameter per physician ord 4) Monitoring of corrective action to ensure the alleged deficient practice d not recur. The Director of Nursing or designee will complete observation au on 3 residents per week x 4 weeks the monthly x 3 months on Licensed nurse administering Jet nebulizers treatment	dits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
		495227	B. WING _		-	01/1	6/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STA 7300 FOREST AVE RICHMOND, VA 23226	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 658	in corridor, locomotic use and personal hytreatments, procedur resident as receiving out of seven days for The physician order "Albuterol Sulfate (ar (4) Nebulization Solugive one vial inhale of a day for wheezing. The MAR (medication Resident #81 document the Albuterol nebulizor ordered by the physician was initiated on 10/2. The care plan dated Problem: "At risk for related to asthma revillated to asthma revillated to asthma revillated. Nebulizer treordered. Revised 12. The physician progres 12:28 PM, document and evaluated. Med reviewed, continue as On 1/14/20 at 11:40. Resident #81 holding area. The medication #81's room nor within On 1/15/20 at 10:10.	assistance for transfer, walk on on/off unit, dressing, toilet giene. Section O-special res and programs coded the prespiratory therapy seven at least 15 minutes a day. Idated 10/22/19 documented, inti-asthmatic, bronchodilator) ation 2.5 milligram/3 milliliter brally via nebulizer two times In administration record), for mented the administration of er two times a day as cian since the date the order 2/19. 8/27/18, documented in part, respiratory impairment wised 12/13/19." The 3/27/18, documented, ons/treatments per physician eatment and medications as 2/13/19." Pess note dated, 12/30/19 at ted in part, "Patient assessed ications and allergies were	F	remain room until cophysician orders. A and 24 hour report administration of propain level rating is a pain level paramete weekly x 4 weeks a months. The audits quality assurance a	an audit of the EMAR to review the n pain medications padministered to the per per physician order nd then monthly x 3 will be reviewed in the nd performance ss for tracking/trendireded.	er r he	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	, , , , , , , , , , , , , , , , , , ,		X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16	6/2020	
	ROVIDER OR SUPPLIER	O NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	#10, regarding the proadministering nebuliz. LPN #10 stated, "We respiratory and pulse minutes after the nebulizer treatment, the place it [nebulizer] need to clean the mast document the administ [treatment]." An interview was considerative staff in nursing, on 1/15/20 at describe the nebulize ASM #2 stated, "The respiratory rates are ris administered." Whistaff follows for monitonebulizer treatment, Athem to see the reside in their room as long a sight. If the resident hassessment, that allow the nurse does not had on't have anyone than nebulizers in the facility professional standard ASM #2 stated, "We for procedures first, and the control of the procedures first, and the control of the procedures for the procedures." The facility's "Specific Procedures-Oral Inha dated 2/2019, documents with the procedures of the control of the procedures of	check the resident's rate, and recheck about 10 ulizer treatment. We stay they are getting the hen when they are finished; in a plastic bag. We may sk with soap and water. We stration of the nebulizer ducted with ASM hember) #2, the director of the 4:00 PM. When asked to r administration procedure, resident's heart and monitored, and the nebulizer en asked about the process oring the resident during the ASM #2 stated, "I expect ent. They do not have to be as they are in their line of has a self-medication we them to self-administer, have to watch them. We at can self-administer ty now." When asked what as of care the facility follows, follow our policies and then we may use Medication Administration lation Administration Policy" ents, "Remain with the hent unless the resident has	F 65	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		01/16/2020
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 658	Continued From pa	nge 106	F 658	3	
	corporate represen	istrator, and ASM #3, the tative were made aware of the 1/15/20 at 5:05 PM.			
	No further informat	ion was provided prior to exit.			
	Non-Medical Readd Chapman, page 12 (2) Barron Dictional edition, Rothenberg (3) Barron's Diction Non-Medical Readd Chapman, page 24 (4) 2019 Lippincott Nurses, Wolters and 2. Resident #57 was 11/21/2019. Diagno limited to joint replat weakness, and mo most recent Minimulassessment was a with an Assessment 11/28/2019. The Br (BIMS) scored Res cognitive impairme	ary of Medical Terms, 7th g and Kaplan, page 54. Terms for the er, 7th edition, Rothenberg and 55. Pocket Drug Guide for d Kluwer, page 9. Tes admitted to the facility on pages included but are not accement surgery, muscle roid obesity. Resident #57's turn Data Set (MDS) Medicare 5 Day Assessment at Reference Date (ARD) of the Interview for Mental Status ident #57 at a 15, indicating no not. Resident #57 was coded as assistance of 1 person for			
	revealed that Resid Oxycodone 20mg (needed for pain, da 01/06/2020. The or pain level paramete the medication to the	nt #57's medical record dent #57 had had an order for a narcotic painkiller) as ated from 12/27/2019 to der did not have or include any ers, for the administartion of the resident. Further review of dication orders revealed that			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495227	B. WING			01/	16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	·	73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	hours as needed for 11/21/2019 to the primedication Orders in defined in the pain is 1, 2, 3, or 4". The oradministered with a occasions as follows. The morning of 01/0 The afternoon of 01. The evening of 01/0 The afternoon of 01. The morning of 01/0 The afternoon of 01. The world with Reg regarding treatment what should be done pain medication. RN #4 should be done pain medication. RN #4 should for what lever the would of options first. Then where the would of options first. Then where the go with the less in asked if she would of Tylenol for "mild" pare follow the parameter they try to offer thing. A review of the facilit Pain Medication" review of the facilit Pain Medication" review of the facilit Pain Medication medication in the Administer pain the Administer pain the Administer pain medication in the Administer pain the	vienol 325mg 2 tablets every 6 mild pain, was in place from esent. Further review of the evealed that "mild pain" was iscale order as "pain rating of exycodone was listed as pain rating of 1 to 4 on 5 s: 2/2/2020 for a rating of 3 //02/2020 for a rating of 4 //05/2020 for a rating of 4 //05/2020 for a rating of 4 //05/2020 for a rating of 1 32p.m. an interview was istered Nurse (RN) #4 of pain. RN #4 was asked as if an order of as-needed not have a parameter yel of pain to administer the estated "We would call the eters." When asked how staff ation to give if more than one dication is presribed, RN #4 fer non-pharmacological re would give medication esident rates their pain. We try intense medication first." When ever offer Oxycodone before in, RN #4 stated she would re of the orders, but generally ge like Tylenol first. Ty policy titled, "Administering yealed the following under the	F	6558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '			(X3) DATE SURVEY COMPLETED	
	495227	B. WING _			01/16/2020	
	NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226			
EFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG	((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
and Recordocument anagement hould be ment guissible, and plest regulation of the proaches of the properties of the prope	gnition, 2001, revised ted in part, ent2. a. Pain selected based on delines. Generally, and to analgesic regimen should imen and lowest risk ing more problematic or s." Itt Manual of Nursing en: by Lippincott Williams & el following is documented Orders: 2. Although you follow an order you think is to ignore a medical order, ending physician, discussin, obtain appropriate envolved medical and independent of the findings at the end of 16/2020. No further footided. admitted to the facility on dimission on 08/02/2016, cluded but were not limited to uscle weakness and elected in a 15 on the staff.	F	558			
TINT COURSED WILDONGS SIDE WITH SUISO	om page and Record document guissible, an aplest registronnot justically for annot justically for annotation for a	IDENTIFICATION NUMBER:	#10ENTIFICATION NUMBER: #95227 #10N AND NURSING CENTER #10N AND NURS	A BUILDING 495227 B. WING STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226 MANARY STATEMENT OF DEFICIENCIES EFFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) DOMIN page 108 and Recognition, 2001, revised documented in part, lanagement2. a. Pain should be selected based on thent guidelines. Generally, and to sable, an analgesic regimen should splest regimen and lowest risk pefore using more problematic or proaches." "Lippincott Manual of Nursing that Edition: by Lippincott Williams & top 15, the following is documented propriate Orders: 2. Although you natically follow an order you think is annot just ignore a medical order, all the attending physician, discuss s with him, obtain appropriate lotify all involved medical and nonel d. Document clearly." Pe Staff Member (ASM) #1, the and ASM #2, the Director of informed of the findings at the end go no 01/16/2020. No further in was provided. #139 was admitted to the facility on with a readmission on 08/02/2016, so that included but were not limited itis (1), muscle weakness and 9's most recent MDS (minimum uarterly assessment with an ARD reference date) of 01/02/20, coded 9, as scoring a 15 on the staff or mental status (BIMS) of a score	A BUILDING	

` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	daily decisions. Sec as having pain almo On 01/14/19 at apprinterview was condu Resident #139 state due to her osteoarth bed. When asked if Resident #139 state her pain on a one to her as needed pain stated that she is on and takes as needed through pain. The POS (physician (January) 8, 2020" for documented the follopain medication: -"Hydroco/Apap (metab 5-325 mg (milliguevery 6 (six) hours apain, Order Date: 6/05/15/2019." -"Oxycodone Tab (tatablet orally every 4 breakthrough pain, Oder Date: 05/16/2019." -"Oxycodone Tab 20 every 4 (four) hours pain, Order Date: 03/05/16/2019." The POS failed to evadministration of the pain medications. The comprehensive documented, "Residented of the pain medications."	st constantly. oximately 1:45 p.m., an cted with Resident #139. d that she frequently has pain ritis and being confined to the the staff assess her pain, d that the staff ask her to rate ten scale before she takes medication. Resident #139 scheduled pain medication d pain medication for break s order sheet) dated "Jan or Resident #139 owing as needed orders for edication used to treat pain) fram) Give 1 (one) tablet orally is needed for breakthrough	F 6:	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			01.	/16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER	•	7300 I	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE MOND, VA 23226	•	
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page 10/21/2015; Revision "Interventions/Tasks PRN (as needed) me breakthru [sic] pain a 01/09/2020." The eMAR (electron record) dated "11/1/2 documented the same documented above in eMAR revealed Hydromas administered on time: -On "11/10/19 0641 (Further review of the Oxycodone Tab 20 in administered on the e-On "11/1/19 0611 (6:11 a a a a a a a a a a a a a a a a a a	e 110 n on 10/22/2019." Under "it documented, "Administer edications as ordered for as needed. Date Initiated ic medication administration 2019-11/30/2019" ne orders, that were in the POS, review of the rocod/Apap Tab 5-325 mg is the following dates and (6:41 a.m.) Pain Level 5." e eMAR revealed that ing 1 (one) tablet was following dates and time: 6:19 a.m.), Pain Level 5, a.m.), Pain Level 4, a.m.), Pain Level 7, a.m.), Pain Level 7, a.m.), Pain Level 5, p.m.), Pain Level 5, p.m.), Pain Level 5, a.m.), Pain Level 4, a.m.), Pain Level 4,		658			
	-11/18/19 0555 (5:55 -11/19/19 0626 (6:26 -11/20/19 0617 (6:17 -11/20/19 1322 (1:22 -11/22/19 0544 (5:44 -11/23/19 0641 (6:41 -11/24/19 0550 (5:50 -11/25/19 0639 (6:30 -11/29/19 0542 (5:42	a.m.), Pain Level 6, a.m.), Pain Level 6, p.m.), Pain Level 9, a.m.), Pain Level 5, a.m.), Pain Level 6, a.m.), Pain Level 6, a.m.), Pain Level 6, a.m.), Pain Level 6,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		(01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 658	Further review of the Oxycodone tab 20 m administered on the -On "11/7/19 0604 (6:44-11/13/19 0604 (6:06-11/26/19 1639 (4:38-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0609 (6:08-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 0619 (6:12-11/28/19 1619 (4:12-11/28/19 1619 (4:12-11/28/19 1619 (4:12-11/28/19 1619 (4:12-11/28/19 0607 (6:08-1	6 a.m.), Pain Level 6." e eMAR revealed that ng 2 (two) tablets was following dates and times: 6:04 a.m.), Pain Level 4, 6 a.m.) Pain Level 5, 9 p.m.) Pain Level 5, 9 p.m.) Pain Level 5." ic medication administration 2019-12/31/2019" ne physician orders POS above, review of the rocod/Apap Tab 5-325 mg in the following dates and (3:46 p.m.) Pain Level 8." e eMAR revealed that mg 1 (one) tablet was following dates and time: 6:04 a.m.), Pain Level 8, a.m.), Pain Level 6, a.m.), Pain Level 5, a.m.), Pain Level 5, a.m.), Pain Level 6, p.m.), Pain Level 6, p.m.), Pain Level 6, p.m.), Pain Level 9, a.m.), Pain Level 6,	F	558		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495227	B. WING			01/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	-12/17/19 0622 (6:22 -12/18/19 0645 (6:45 -12/19/19 0551 (5:51 -12/20/19 0608 (6:08 -12/22/19 0621 (6:21 -12/23/19 1629 (4:29 -12/25/19 0542 (5:42 -12/26/19 0724 (7:24 -12/27/19 0602 (6:02 -12/27/19 1249 (12:4 -12/28/19 1506 (3:06 -12/30/19 0553 (5:53 -12/30/19 1131 (11:3 Further review of the Oxycodone tab 20 m administered on the f -On "12/1/19 0609 (6:09 a -12/3/19 0630 (6:30 a -12/2/1/19 0630 (6:06 -12/29/19 0644 (6:44 -12/30/19 1605 (4:05 The eMAR (electronic record) dated "1/1/20 the same physician o POS above, review o Oxycodone Tab 20 m administered on the f	a.m.), Pain Level 6, a.m.), Pain Level 5, a.m.), Pain Level 6, a.m.), Pain Level 6, a.m.), Pain Level 6, p.m.) Pain Level 8, a.m.) Pain Level 6, a.m.) Pain Level 6, a.m.) Pain Level 6, a.m.) Pain Level 9, a.m.) Pain Level 9, a.m.) Pain Level 6, p.m.) Pain Level 6, p.m.) Pain Level 6, 1 a.m.) Pain Level 6." eMAR revealed that g 2 (two) tablets was ollowing dates and times: :00 a.m.), Pain Level 5, a.m.) Pain Level 6, p.m.) Pain Level 6, a.m.) Pain Level 7." c medication administration 20-1/31/2020" documented rders as documented in the f the eMAR revealed that g 1 (one) tablet was ollowing dates and time: 15 a.m.), Pain Level 6, m.), Pain Level 8,	F 65	8		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226		3 11 10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	conducted with LPN the unit manager. W which to administer in needed pain medica that the physician's of determine which to guern that the physician's of determine which to guern that the nurse should clarify the orders. Left for Resident #139 which the nurse should clarify the orders. Left for Resident #139 which the nurse should clarify the orders. Left for Resident #139 which the nurse should clarify the orders. Left for Resident #139 which the nurse should clarify the orders. Left for Resident #139 which the nurse should clarify the orders. Left for Resident #139 which the nurse should clarify the orders. Left for Resident #139 which the nurse should clarify the orders. Left for hydroco/Apap tall or hydroco/Apap tall or hydroco	.m.), Pain Level 8, .m.), Pain Level 7, a.m.), Pain Level 6, a.m.), Pain Level 6, a.m.), Pain Level 6, a.m.), Pain Level 4, a.m.), Pain Level 5, p.m.), Pain Level 9, B.p.m.), Pain Level 9, a.m.), Pain Level 6." p.m., an interview was (licensed practical nurse) #4, hen asked how staff know f a resident has multiple as tions ordered, LPN #4 stated orders have a scale to give for each severity of pain. he orders should say for mild, pain so that the staff can give based on the pain scale about orders for multiple as ations without any ordered, dministration, LPN #4 stated d contact the provider to PN #4 then reviewed the POS hich documented the orders to 5-325 mg 1 (one) tablet	F 6:	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 658	#4 stated that she waresident had a prefer she would have the clevel parameters for administration of the for Resident #139. The facility policy "Pa Assessment and Rec March 2018" docume "Treatment/Managem order appropriate nor medication intervention individual's pain. a. F selected based on performed by the selected by the selected based on performed by the selected by the	ister to Resident #139, LPN is not sure unless the ence. LPN #4 stated that refers clarified to have pain staff to follow for the as needed pain medications in-Clinical Protocol, ognition, 2001, revised in part, inent2. The physician will in-pharmacologic and ons to address the Pain medications should be entinent treatment guidelines. extent possible, an ould utilize the simplest isk medications before using higher risk approaches." ximately 5:15 p.m., ASM member) #1, the 2, the director of nursing, director of clinical services dical director were made	F 65	,		
	Osteoarthritis is a when the tissues in the time. It is the most comore common in older obtained from the	joint disease that happens ne joint break down over mmon type of arthritis and is er people. Information niams.nih.gov/health-topics/o				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	ID NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 658	Continued From pag steoarthritis	e 115	F 658			
F 684 SS=D	Quality of Care CFR(s): 483.25		F 684		2/17/20	
	applies to all treatmet facility residents. Base assessment of a resist that residents received accordance with protipractice, the comprecare plan, and the residents review, and clinical review, and clinical review, and clinical review, and clinical residents in the surveand #144). The facility physician prescribed severe pain for the answer of the prescribed parant multiple occasions in January 2020. The findings include: 1. Resident # 64 was assessment of a resident #144 for passessment # 144 for p	andamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure entreatment and care in fessional standards of hensive person-centered esidents' choices. This not met as evidenced eview, facility document eccord review, it was facility staff failed to provide ensistent with professional end, and the comprehensive end of care for two of 60 ey sample, (Residents # 64, ity staff failed to follow the pain level parameter of dministration of as needed ent #64 for pain ratings below meter of severe pain on a December 2019 and acility staff administered d pain medications to ain level ratings that were prescribed parameters.		F684 Quality of Care 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #64 has be discharged. Resident #144 nurses were ducated on administration of prn pain medications pain level rating is administered to the pain level parametroper physician order and documentation supports nonpharmacological interventions are attempted prior to administration of prn pain medication. 2) Corrective Actions taken for resident with potential to be affected by alleged deficient practice. Residents that have pain medications have the potential to affected. The Director of Nursing or designee will complete an audit of the EMAR (electronic medication administration record), 24 hour report documentation to review administration prn pain medications per pain level rations administered to the pain level	een ee er d ss prn be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				01/16/2020
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				7300	FOREST AVE		
WESTPOR	RT REHABILITATION	AND NURSING CENTER		RICI	HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From p	page 116	F 6	684			
	-	order, unspecified hip, and			parameter per physician order and		
		al cavity [inside the nose].			documentation supports		
		a. cavity [c.ac a.cccc].			nonpharmacological interventions are	a	
	Resident # 64's m			attempted prior to administration of p			
	set), an admissio			pain medication.			
	(assessment refe			3) Systemic Changes put into place t	0		
	Resident # 64 as scoring a 12 on the brief			Ε	ensure the alleged deficient practice	does	
	interview for men		r	not reoccur. In-service for the Licens	ed		
		ognitively intact for making daily		1	Nurses will be completed by the Dire	ctor	
		ent # 64 was coded as requiring			of Nursing or designee on the proced		
		nce of one staff member for			or administration of prn pain medica		
		iving. Section J "Health			per pain level rating is administered t		
		d Resident # 64 as having			pain level parameter per physician o	der	
		a pain level of four on a scale			and documentation supports	_	
	of zero to ten witr	ten being the worse pain.			nonpharmacological interventions are		
	The DOS Inhysisi	an'a order shoot] datad			attempted prior to administration of p	m	
		an's order sheet] dated esident # 64 documented,		1 -	pain medication. 1) Monitoring of corrective action to		
		et 5MG [five milligrams]. Give			ensure the alleged deficient practice	does	
		every 12 hours as needed for			not reoccur. The Director of Nursing		
		≥ ½ [half] of 5mg tablet to equal			designee will complete an audit of the		
	2.5mg. Order Da				EMAR and 24 hour report to review		
					administration of prn pain medication		
					pain level rating is administered to th		
	Resident # 64's e	MAR [electronic medication			pain level parameter per physician o		
		cord] dated December 2019		6	and documentation supports		
	documented the	physician's order as above. The		r	nonpharmacological interventions are)	
	eMAR also docur	nented, "Pain Score every shift;		a	attempted prior to administration of p	rn	
		three, four] = Mild Pain; 5, 6, 7			oain medication weekly x 4 weeks ar		
		Moderate Pain; 8,9,10 [eight,			hen monthly x 3 months. The audits		
	_	re Pain." The eMAR failed to			pe reviewed in the quality assurance		
		entation of non-pharmacological			performance improvement process for	r	
		rther review of the eMAR			racking/trending and revisions as		
		inistration of Oxycodone on:			needed.		
		o.m. with a pain level of five.		5	5)Date of compliance- 2/17/2020		
		o.m. with a pain level of four.					
		o.m. with a pain level of four. o.m. with a pain level of six.					
		o.m. with a pain level of five.					
	12/13/13 al 3.22	o.iii. willi a paili level Ol live.	1				1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	and at 9:14 p.m. wit 12/28/19 at 9:51 p.r 12/29/19 at 9:30 p.r 12/30/19 at 9:30 p.r Resident # 64's eM administration record documented the phye MAR also docume 1,2,3,4 [one, two, th [five, six, seven] = N nine, ten] = Severe evidence document interventions. Furth revealed the admini 01/03/20 at 9:33 p.r 01/06/20 at 10:19 p 01/07/20 at 9:00 p.r 01/08/20 at 8:23 p.r 01/11/20 at 8:24 p.r Review of the nurse through 01/15/2020 documentation of at interventions prior to needed pain medicate the physician was in administered for pais servere [eight, nine, On 01/15/20 at 2:02 conducted with LPN 4, the unit manager LPN #4 asked to de follows for the admin pain medication. LP	m., with a pain level of six h a pain level of four. n. with a pain level of three. n. with a pain level of four. n. with a pain level of four. n. with a pain level of three. AR [electronic medication d] dated January2020 ysician's order as above. The nted, "Pain Score every shift; ree, four] = Mild Pain; 5, 6, 7 Moderate Pain; 8,9,10 [eight, Pain." The eMAR failed to ation of non-pharmacological er review of the eMAR stration of Oxycodone on: n. with a pain level of three. m. with a pain level of two. n. with a pain level of four. n. with a pain level of three. n. with a pain level of thr	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _	· · · · · · · · · · · · · · · · · · ·		1/16/2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	prescribed, attem interventions to all helpful offer the proof pain. If pain monon-pharmacolog effective you would asked how often to checked, LPN # 4 documented every shift on the eMAR administration reconstruction of the facility pain scale. After administration of the stated above physician order where the extent possiblutilize the simples medications befor high risk approach.	e pain, check to see what is pt non-pharmacological leviate the pain, if it was not ain medication for the severity edication is not available and ical interventions are not ld call the physician." When the pain level of a resident is stated, "The pain level is y shift at any time during the lelectronic medication cord] or in the nurse's notes." e "Pain Scores" on Resident # # 4 stated that is what the low to determine the resident's reviewing, the eMAR for the Oxycodone on the dates and e LPN # 4 was asked if the las being followed. LPN # 4 "Pain - Clinical Protocol" art, "Treatment/Management: [2] order appropriate ical and medication ddress the individual's pain. a. should be selected based on at guidelines. Generally, and to le, an analgesic regimen should be tregimen and lowest risk the using more problematic or mes." approximately 5:40 p.m. ASM aff member] # 1, the M # 2, director of nursing, were	F6	884			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	12/28/19 with diagnorm not limited to: nondishumerus (arm), repeared an emia, malnutrition and high blood press. The most recent MD assessment, an admassessment reference the resident as scori interview for mental resident was severed cognitive decisions. requiring extensive a activities of daily living Conditions the reside pain upon interview. The physician order documented, "Aceta treat mild to moderar (milligram); Give 2 transparence as needed for Mild F to treat moderate to tablet by mouth ever (moderate)/severe pure the December 2019 administration record every shift: 0 = Nop 6, 7 = Moderate pain. The December 2019 Oxycodone was admidates, times and for 12/28/19 at 9:03 p.m. 12/29/19 at 3:37 p.m.	as admitted to the facility on oses that included but were splaced fracture of the stated falls, muscle weakness, dementia, anxiety disorder, sure. S (minimum data set) mission assessment, with an ose date of 1/2/2020, coded ong a five on the BIMS (brief status) score indicating the lay impaired to make daily Resident #144 was coded as assistance for all of her ong. In Section J - Health ent was coded as having no dated, 12/28/19, minophen (Tylenol) (used to be pain) (1) tablet 325 MG ablet by mouth every 6 hours that one can be a severe pain) (2) 5 MG; give 1 by 6 hours as needed for mod ain." MAR (medication di) documented a "Pain Score ain; 1, 2, 3, 4 = Mild Pain; 5, and 3, 8, 9, 10 = severe pain." MAR documented the ministered on the following pain scale ratings as follows: and pain level = 2	F 68	34			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page	ge 120	F 6	84		
		o Resident #144 for mild pain moderate to severe pain as sician.				
	physician order abo Tylenol was, not do The Oxycodone wa administered on the pain scale: 1/2/2020 at 6:38 a.r 1/4/2020 at 6:11 p.r 1/5/2020 at 8:47 p.r 1/8/2020 at 3:35 p.r 1/9/2020 at 6:00 p.r 1/10/2020 at 7:17 p 1/11/2020 at 5:54 p 1/12/2020 at 6:15 a 1/12/2020 at 8:41 a Of these ten doses per the physician or The remaining dose pain ratings. Review of the nurse and dates in Decem failed to document a interventions provid of the pain medicati The comprehensive documented in part fractures." The "Inte part, "Administer pa orders. Implement	e following dates, time and the m pain level 4 m pain level 3 m pain level 6 m pain level 6 m pain level 4 m pain level 4 m pain level 6 m pain level 6 m pain level 5 m pain level 5 m pain level 6 der for moderate/severe pain. es were administered for mild es were administered for mild es notes for the above times abor 2019 and January 2020 any non-pharmacological ed prior to the administration ons. e care plan dated, 12/30/19 g "Focus: Pain related to erventions" documented in an medications per physician nondrug therapies such as ties, to assist with pain and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	495227 B. WING			0	1/16/2020			
	ROVIDER OR SUPPLIER	AND NURSING CENTER	,	7300 FC	ADDRESS, CITY, STATE, ZIP CODE DREST AVE IOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	Continued From p		F	584				
	practical nurse) #7 the pain medicatic a.m. When asked severe pain is, LP things depending and oriented they tell me what level if there is a definiti scale, LPN #7 stat it (pain) goes up o above MAR with the reviewed with LPN aware of the above pain medication to she was aware of some with her initi #7. When asked if physician order when medication for pain	conducted with LPN (licensed 7, a nurse that had administered ans above, on 1/16/2020 at 8:45 what mild, moderate and N #7 stated it could be different on the patient. If they are alert can tell me about their pain and on the pain scale." When asked on of the levels of the pain sed, "It's listed as zero to ten, as in the scale, I don't know." The ne pain scale definition was I #7. When asked if she was a pain rating scale when giving a Resident #144, LPN #7 stated the scale. The MARs above, als, were reviewed with LPN she was following the nen she gave the pain a ratings below the physician wel parameter, LPN #7 stated,						
	administrator and	ff member (ASM) #1, the ASM #3, the corporate nurse, of the above concern on p.m.						
	No further informa	tion was provided prior to exit.						
	following website: https://medlineplustml	n was obtained from the s.gov/druginfo/meds/a681004.h						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020
	ROVIDER OR SUPPLIER	ID NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684	meta?v%3Aproject= medlineplus-bundle&	nih.gov/vivisimo/cgi-bin/query- medlineplus&v%3Asources= kquery=oxycodone	F 684		
F 757 SS=E	Drug Regimen is Fre CFR(s): 483.45(d)(1) §483.45(d) Unneces Each resident's drug unnecessary drugs. drug when used- §483.45(d)(1) In exc duplicate drug therap (s483.45(d)(2) For exc (s483.45(d)(3) Without use; or (s483.45(d)(5) In the consequences which reduced or discontin (s483.45(d)(6) Any consequences which reduced or discontin	see from Unnecessary Drugs 0-(6) sary Drugs-General. regimen must be free from An unnecessary drug is any essive dose (including by); or cessive duration; or ut adequate monitoring; or ut adequate indications for its presence of adverse indicate the dose should be ued; or ombinations of the reasons (d)(1) through (5) of this T is not met as evidenced view and clinical record nined that the facility staff medication regimen for three ents, (Resident #64, and unnecessary medication. The implement and monitor the	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1) Corrective Action for those resident found to be affected by the alleged deficient practice. Resident #53, #64 h been discharged, #135 and #144 nurs were educated on administration of	ave

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _	WING			01/16/2020
NAME OF PR	ROVIDER OR SUPPLIER	·	1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	10.2020
				7	300 FOREST AVE		
WESTPOR	RT REHABILITATION A	AND NURSING CENTER		R	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From pa	age 123	F	757			
	•	ne plan of care prior to			medications per physician orders and		
		eeded (prn) Oxycodone pain			nonpharmacological interventions prior	r to	
		dent # 64 and the staff			administration of prn pain medication.		
		s needed pain medication for			Corrective Actions taken for residen	ts	
	pain level ratings that were below the physician				with potential to be affected by alleged		
	prescribed parameters. The facility staff failed to				deficient practice. Residents that have		
	attempt non-pharmacological interventions prior				pain medications have the potential to	•	
	to the administration of the prn (as needed) pain				affected. The Director of Nursing or		
	medication Acetaminophen [1] to Resident # 53				designee will complete an audit of the		
		5. The facility staff failed to			EMAR (electronic medication		
		nacological interventions prior			administration record), physician order	'S	
		on of as needed pain			and 24-hour report documentation to		
		dent #144 and the staff			review for administration of prn pain		
	administered prescribed as needed pain				medication and documentation suppor	ts	
	•	sident #144 for pain level			non-pharmacological interventions wei		
		elow the physician prescribed			attempted prior to administration of the		
	parameters.	. , .			prn pain medication.		
	•				3) Systemic Changes put into place to		
	The findings includ	le:			ensure the alleged deficient practice de		
	•				not reoccur. In-service for the Licensed		
	1. Resident # 64 w	as admitted to the facility with			Nurses will be completed by the Direct	or	
	diagnoses that incl	uded but were not limited to:			of Nursing or designee on documentat	ion	
	specified joint diso	rder, unspecified hip, and			to support non-pharmacological		
	cancer of the nasa	I cavity [inside the nose].			interventions were attempted prior to tl	ne	
					administration of a prn pain medication	١.	
		ost recent MDS (minimum data					
	set), an admission	assessment with an ARD			4) Monitoring of corrective action to		
		ence date) of 12/02/19, coded			ensure the alleged deficient practice de	oes	
		coring a 12 on the brief			not recur. The Director of Nursing or		
		al status (BIMS) of a score of 0			designee will complete an audit of the		
		gnitively intact for making daily			EMAR, physicians orders and 24 hour		
		nt # 64 was coded as requiring			report documentation to review if prn p	ain	
		ce of one staff member for			medication administered has		
		ring. Section J "Health			documentation supports		
		Resident # 64 as having			nonpharmacological interventions were		
		a pain level of four on a scale			attempted prior to administration of the		
	of zero to ten with	ten being the worse pain.			prn pain medication weekly x 4 weeks		
					then monthly x 3 months. The audits w		
	The POS [physicia	n's order sheet] dated			be reviewed in the quality assurance a	nd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	495227 B. WING			01/	16/2020		
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		73	800 FOREST AVE		
WESTFOI	NI NEHABIEHAHON AN	D NORSING CENTER		RI	ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From page	e 124	F 7	757			
	01/01/2020 for Resid "Oxycodone Tablet 5 0.5 mg by mouth eve	ent # 64 documented, MG [five milligrams]. Give ry 12 hours as needed for [half] of 5mg tablet to equal			performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020		
	dated 12/05/2019 doc left hip related to chro Initiated: 12/05/2019. documented, "Implen	care plan for Resident # 64 cumented, "Focus: Pain to onic left hip pain. Date " Under "Interventions" it nent nondrug therapies such vities, to assist with pain and ess. Date Initiated:					
	administration record documented the physe eMAR also document 1, 2, 3, 4 [one, two, that 7 [five, six, seven] = I [eight, nine, ten] = Sefailed to evidence do non-pharmacological review of the eMAR rof Oxycodone on the scale ratings as follow 12/01/19 at 8:43 p.m. 12/05/19 at 8:37 p.m. 12/16/19 at 8:17 p.m. 12/17/19 at 2:37 p.m. 12/17/19 at 2:37 p.m. 12/19/19 at 12:39 p.m. 12/26/19 at 12:00 a. I and at 9:14 p.m. with 12/28/19 at 9:23 p.m. 12/29/19 at 9:23 p.m. 12/29/19 at 9:23 p.m.	interventions. Further evealed the administration dates and times for pain vs: with a pain level of five. with a pain level of four. with a pain level of four. with a pain level of nine. with a pain level of six. with a pain level of five. n. with a pain level of eight. m., with a pain level of six					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757	Continued From pa	ge 125	F 7	57		
	administration record documented the phe MAR also documented the phe MAR also documented to the phe MAR also documented to the phe MAR also documented to the period of the period of the phe management of the phe manageme					
	conducted with Res	p.m., an interview was ident # 64. When asked if the viate the pain before kycodone, Resident # 64				
	conducted with LPN 4-unit manager regaling LPN #4 was asked the administration of medication. LPN # pain, one to ten, with the location of the pain.	2 p.m., an interview was I [licensed practical nurse] # arding pain management. to describe the procedure for f a prn [as needed] pain 4 stated, "Assess level of the ten being the worse pain, ain, check to see what is empt non-pharmacological				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 757	helpful offer the p of pain. If pain m non-pharmacolog effective you wou # 4 reviewed the o oxycodone to Res times listed above 12/01/2019 throug asked if there was non-pharmacolog stated no. When documentation ind don't know if it is it documented." Wh level of a resident "The pain level is time during the sh medication admin nurse's notes." A on Resident # 64' what the nurse's or resident's pain so for the administra and times listed a physician order w stated no. The facility policy documented in pa The physician will non-pharmacolog interventions to ac Pain medications pertinent treatment the extent possibl utilize the simples	leviate the pain, if it was not ain medication for the severity edication is not available and ical interventions are not id call the physician." After LPN eMARs for the administration of sident # 64 for the dates and and the nurse's notes dated in 01/15/2020, LPN # 4 was adocumentation of ical interventions. LPN # 4 asked what the lack of dicated LPN # 4 stated, "You being done if it is not en asked how often the pain is checked, LPN # 4 stated, documented every shift at any ift on the eMAR [electronic istration record] or in the fter reviewing the "Pain Scores" is eMAR, LPN # 4 stated that is would follow to determine the ale. After reviewing, the eMAR tion of Oxycodone on the dates bove, LPN # 4 was asked if the as being followed. LPN # 4 "Pain - Clinical Protocol" art, "Treatment/Management: [2] order appropriate ical and medication ddress the individual's pain. a. should be selected based on at guidelines. Generally, and to be, an analgesic regimen should to regimen and lowest risk the using more problematic or	F7	757			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 757	Continued From pa	age 127	F 757			
	[administrative staf administrator, ASM made aware of the	# 2, director of nursing, were findings.				
		ion was provided prior to exit.				
	severe pain. This i the website:	sed to relieve moderate to nformation was obtained from .gov/druginfo/meds/a682132.h				
	set), an admission (assessment refere coded Resident # 5 assessment for me of 0 - 15, 14- being daily decisions. Re requiring extensive member for activitie	assessment with an ARD ence date) of 11/27/2019, 53 as scoring a 14 on the staff ental status (BIMS) of a score cognitively intact for making esident # 53 was coded as assistance of one staff es of daily living. Section J " coded Resident # 3 as having in.				
	01/01/2020 for Res "Acetaminophen Ta 2 [two] tablet by mo	n's order sheet] dated sident # 53 documented, ablet 325MG [milligrams]. Give outh every 6 [six] hours as in. Order Date: 11/21/2019."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			1/16/2020
	ROVIDER OR SUPPLIER	.ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
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F 757	Continued From pa	ge 128	F 7	57		
	administration reco documented the phe MAR also documented to phe MAR also documented to evidence of non-pharmacologic review of the eMAR of Acetaminophen of follows: 11/23/19 at 12:51 phe and at 8:22 p.m. wind 11/25/19 at 4:48 p.m. 11/26/19 at 12:37 and at 8:47 p.m. wind 11/27/19 at 8:32 p.m. Winderson the phe market with the phe market for th	al interventions. Further a revealed the administration on the dates and times as .m. with a pain level of three th a pain level of three. m. with a pain level of four .m. with a pain level of four th a pain level of five. m. with a pain level of four.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020
	ROVIDER OR SUPPLIER	AND NURSING CENTER	73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE ICHMOND, VA 23226	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 757	interventions to alle helpful offer the pai of pain. If pain men non-pharmacologic effective you would # 4 reviewed the el Acetaminophen to and times listed ab dated 11/23/2019 the was asked if there attempt of non-pha LPN # 4 stated no. documentation indi don't know if it is be documented." On 01/15/2020 at a [administrative staff administrative staff administra	empt non-pharmacological eviate the pain, if it was not in medication for the severity dication is not available and call interventions are not a call the physician." After LPN MAR for the administration of Resident # 53 for the dates ove and the nurse's notes hrough 11/30/2019, LPN # 4 was documentation of the rmacological interventions. When asked what the lack of cated LPN # 4 stated, "You being done if it is not approximately 5:40 p.m. ASM of member] # 1, the a # 2, director of nursing, were	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	B. WING		01/16/	2020	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE C	(X5) OMPLETION DATE	
F 757	pain, swelling, and It can occur in any hands, knees, hips was obtained from https://medlineplus [3] Makes your bor break. This inform website: https://www.nlm.nifs.html. [4] Poly meaning m This information was https://www.merria Peripheral nerves of the brain. They also spinal cord to the meuropathy means properly. Peripheral because of damagof nerves. It may also body. This information website: https://medlineplus 3. Resident #135 of 12/23/19 with the day.	non form of arthritis. It causes reduced motion in your joints. joint, but usually it affects your or spine. This information the website: gov/osteoarthritis.html. es weak and more likely to ation was obtained from the m.gov/medlineplus/osteoporosi many: several: much: multi-as obtained from the website: m-webster.com/dictionary/poly.carry information to and from the carry signals to and from the est of the body. Peripheral these nerves don't work all neuropathy may occur es to a single nerve or a group so affect nerves in the whole tion was obtained from the agov/ency/article/000593.htm. In the service of the facility on in inagnoses of but not limited to	F 75	<u> </u>			
	stage renal disease osteoporosis, press hyperparathyroidisi dialysis dependent syndrome, pituitary orthostatic tachyca	chostatic hypotension, end e, neurogenic bladder, sure ulcers, hypothermia, m, convulsions, arthritis, diabetic retinopathy, dumping micro adenoma, postural rdia syndrome, and history of the Admission MDS (Minimum					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
495227		B. WING _	B. WING		01/16/2020	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 757	Date) of 12/29/19 co cognitively intact in a decisions. The reside extensive care for batter ambulation out of the bed; limited assistant ambulation in the roof or eating; and was fished bowel and bladder. A review of the facility Protocol documente elements of a comfort appropriate physical interventions; for example and the clinical following physician's 12/23/19 for "Acetam (milligrams) Give 2 to needed for pain." 12/23/19 for "Diclofe Apply 2 gram transder in pain four times and A review of the Dece Administration Record Acetaminophen was 12/25/19, 12/26/19, A review of the Dece that the Diclofenacy was a decision of the Dece that the Diclofenacy was a decision."	2D (Assessment Reference ded the resident as being bility to make daily life ent was coded as requiring athing, toileting, dressing, e room and transfers out of ce for bed mobility, om and hygiene; supervision requently incontinent of cy policy, "Pain - Clinical ed, "Staff will provide the rting environment and and complementary ample, local heat or ice, ge, and the opportunity to in" all record revealed the orders: hinophen (1) Tablet, 325 MG ablet orally every 6 hours as hac (2) Sodium Gel 1% ermally as needed for right day." mber 2019 MAR (Medication rd) revealed that the administered on 12/24/19, 12/27/19, and 12/31/19. mber 2019 MAR revealed	F 7	57		

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495227	B. WING		0	1/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 757	Continued From pag	ge 132	F 7	57		
	Further review of the reveal any documer non-pharmacological or attempted. On 1/16/20 at 9:13 / #8, when asked aboresident complaining a number (0-10), introduced a number (0-10), introduced anything factors, better, offer non-pharmacological or attempted it is a trend, mention different. Document Document pre and procument pre and procument pre and procument pre and procument about non-notes." A review of the complete complete anything about non-notes." A review of the complete complete anything about non-notes." A review of the complete complete anything about non-notes." On 1/16/20 at 9:23 / #9, the unit manage anything about non-notes." A review of the complete complete anything about non-notes." On 1/16/20 at 9:23 / #9, the unit manage anything about non-notes." A review of the complete complete anything about non-notes." On 1/16/20 at 9:23 / #9, the unit manage anything about non-notes."	e clinical record failed to ated evidence of al interventions being offered AM, in an interview with LPN but the procedures for a g of pain, she stated, "Ask for ensity of the pain, what makes it worse or armacological first, then check to see what they have PRN. If a it to the doctor for something the non-pharmacological's. Post pain scale." AM, in an interview with LPN r, she stated, "I don't see pharmacological's in the prehensive care plan for alled one dated 12/24/19 that related to arthritis, rib pain." This care plan intion, dated 12/24/19, for a therapies such as activities, as indicated to assist with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		495227	B. WING		01/16/2020		
	OVIDER OR SUPPLIER T REHABILITATION AI	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226		•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION		
	moderate pain. Information obtained https://medlineplus.gtml (2) Diclofenac - is us osteoarthritis Information obtained https://medlineplus.gml 4. Resident #144 w 12/28/19 with diagnont limited to: non-dhumerus (arm), repeanemia, malnutrition and high blood press. The most recent MD assessment, an admassessment referenthe resident as scori interview for mental resident was severe cognitive decisions. requiring extensive a activities of daily living Conditions the resident was required pain upon interview. The physician order documented, "Aceta treat mild to modera (milligram); Give 2 treat needed for Mild Faceta for mild for Mild Faceta for mild for Mild Faceta for Mild Facet	is used to relieve mild to If from gov/druginfo/meds/a681004.h If from gov/druginfo/meds/a61002.ht If from gov/druginfo/meds/a611002.ht If from gov/druginfo/meds/a611002.ht If sas admitted to the facility on object that included but were displaced fracture of the eated falls, muscle weakness, it, dementia, anxiety disorder, sure. If sure. If sure is the facility on object that included but were displaced fracture of the eated falls, muscle weakness, it, dementia, anxiety disorder, sure. If sure is the facility on object that included but were displaced fracture of the eated falls, muscle weakness, it, dementia, anxiety disorder, sure. If sure is the facility on object that included but were displaced fracture of the eated falls, muscle weakness, it dementia, anxiety disorder, sure. If sure is used to relieve mild to	F 75	57			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495227	B. WING _			01/16/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZI 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 757	every shift: 0 = No pa 7 = Moderate pain; 8, The above physician were documented on In December, the res Tylenol on the followi scale ratings as follow 12/29/19 at 8:05 a.m. 12/31/19 at 5:35 a.m. The December 2019 Oxycodone was adm dates, times for pain a 12/28/19 at 9:03 p.m. 12/29/19 at 3:37 p.m. The January 2020 M/ physician order above Tylenol was, not docu The Oxycodone was,	MAR (medication) documented a "Pain Score iin; 1,2,3,4 = Mild Pain; 5, 6, 9,10 = severe pain." orders for the medications the December 2019 MAR. ident was administered the ng dates and times for pain ws: - pain level = 5 - pain level = 6 MAR documented the inistered on the following scale ratings as follows: - pain level = 2 - pain level = 4 AR documented the e for medications. The umented as administered. documented as following dates, times for follows: - pain level 4 - pain level 4 - pain level 6 - pain level 5	F	757		
	Of these ten doses a	dministered, only four were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE COMF	SURVEY	
		495227	B. WING _	B. WING			01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 757	Continued From pag	ge 135	F	757				
		der for moderate pain. The re administered for mild pain						
	and dates in Decem	's notes for the above times ber 2019 and January 2020 my non-pharmacological ed prior to the administration ons.						
	documented in part, fractures." The "Inte part, "Administer pa orders. Implement I	care plan dated, 12/30/19 "Focus: Pain related to rventions" documented in in medications per physician non-drug therapies such as ies, to assist with pain and ness.						
	practical nurse) #7, the pain medications a.m. When asked we severe pain is, LPN things depending or and oriented they catell me what level or if there is a definition scale, LPN #7 state it (pain) goes up on above MAR with the reviewed with LPN aware of the above pain medication to Fishe was aware of the some with her initial #7. When asked if sphysician order whem medication for pain	nducted with LPN (licensed a nurse that had administered a above, on 1/16/2020 at 8:45 hat mild, moderate and #7 stated it could be different in the patient. If they are alert an tell me about their pain and in the pain scale." When asked in of the levels of the pain d, "It's listed as zero to ten, as the scale, I don't know." The epain scale definition was #7. When asked if she was pain rating scale when giving Resident #144, LPN #7 stated e scale. The MARs above, s, were reviewed with LPN he was following the in she gave the pain ratings below the physician el parameter, LPN #7 stated,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION		ATE SURVEY DMPLETED	
		495227	B. WING _		,	01/16/2020
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757	followed for resident stated, "I ask the para sometimes offer Tyle oriented, I ask them medication. For the see what they are drarea, facial grimace attempts anything property stated, "Sometim pain is." When aske non-medication interproperty before administering medications, LPN # nurse's notes." An interview was conurse) #6, the quality manager, on 1/16/2 what is mild/modera	asked about the process t complaints of pain, LPN #7 in level, the location and enol. If they are alert and their preference for confused resident I watch to oing, flinching, guarding the s." When asked if she rior to giving medication, LPN les, it depends on where the d where staff document if rventions were attempted	F	757		
	and severe pain is ear The pain scale on the RN #6. When asked follows for resident of stated the nurse wo the location, type are nurse should attempt interventions, such a massage, music, so attention on the pair document the non-nattempted, RN #6 state in the progress note. Administrative staff administrator and Asserts	mething to divert their n. When asked where staff nedication interventions ated it should be documented				

, , , , , , , , , , , , , , , , , , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED	
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	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 7300 FOREST AVE RICHMOND, VA 23226	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 757	Continued From pag 1/16/2020 at 1:05 p.r No further informatio		F 7	57			
F 842	following website: https://medlineplus.g tml (2) This information of following website: https://vsearch.nlm.n meta?v%3Aproject=1 medlineplus-bundle& Resident Records - I	dentifiable Information	F 8	42		2/17/20	
SS=D	(i) A facility may not a resident-identifiable of (ii) The facility may resident-identifiable of accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance of the extent of the	nt-identifiable information. release information that is to the public. elease information that is to an agent only in ontract under which the agent disclose the information the facility itself is permitted ecords. rdance with accepted ds and practices, the facility al records on each resident mented; le; and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01/16/2020	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	D BE COMPLETION	
F 842	all information contaregardless of the for records, except when (i) To the individual, representative when (ii) Required by Law (iii) For treatment, properations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial an law enforcement purpurposes, research medical examiners, a serious threat to his by and in compliance §483.70(i)(3) The farecord information and unauthorized use. §483.70(i)(4) Medicator (ii) The period of time (iii) Five years from the there is no requirem (iii) For a minor, 3 years and in sufficient information (iii) A record of the record o	cility must keep confidential ined in the resident's records, m or storage method of the n release isor their resident e permitted by applicable law; ; ayment, or health care litted by and in compliance 6; a activities, reporting of abuse, eviolence, health oversight d administrative proceedings, rooses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. Icility must safeguard medical gainst loss, destruction, or all records must be retained e required by State law; or he date of discharge when ent in State law; or her date o	F 84:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495227		B. WING		01/16/2020	
NAME OF PROVIDER OR SUPPLIE WESTPORT REHABILITATIO		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
(v) Physician's, r professional's professional professional's professional professional professional's professional professional's professional p	conducted by the State; nurse's, and other licensed ogress notes; and radiology and other diagnostic as required under §483.50. MENT is not met as evidenced Interview, facility document review rd review, it was determined the record for one of 60 residents in record for one of 60 residents in record for one of 60 residents in record in the clinical record prior as needed antianxiety resident #144. Inde: Inde: Index admitted to the facility on regnoses that included but were repeated falls, muscle weakness, resident, anxiety disorder, ressure. Index muscle weakness, ressure. Index muscle weakness, ressure. Index muscle weakness, ressure. Index muscle weakness, resident anxiety disorder, ressure. Index muscle weakness, resident anxiety disorder, resident was coded as receiving a five on the BIMS (brief retal status) score indicating the receiver impaired to make daily resident #144 was coded as received anxiety make daily resident was coded as receiving	F 842	F842 Resident Records □ Identifiable Information 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #144 PRN Ativan order has been discontinued. 2) Corrective Actions taken for residen with potential to be affected by alleged deficient practice. Residents that have PRN psychoactive medications ordere by a physician have the potential to be affected. The Director of Nursing or designee will complete an audit of the EMAR (electronic medication administration record), physician order and 24-hour report to review for administration of prn psychoactive medication has documentation of non-pharmacological interventions to support were attempted prior to administration of the prn psychoactive medication. 3) Systemic Changes put into place to ensure the alleged deficient practice do not recur. In-service for the Licensed Nurses will be completed by the Direct of Nursing or designee on documentat of non-pharmacological interventions to support were attempted prior to the administration of a prn psychoactive medications. 4) Monitoring of corrective action to	ts d s oes or ion	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495227	B. WING _			01	//16/2020		
	ROVIDER OR SUPPLIER	D NURSING CENTER	•	73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226	•			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 140	F	842					
	(1) 1 MG (milligram); 8 hours as needed for The MAR (medication January 2020 docum	Tablet (used to treat anxiety) give 1 tablet by mouth every or anxiety." In administration record) for ented the above physician e MAR documented the administered on the mes: In and 11:36 p.m. In and 9:06 p.m. In and 5:59 p.m. In and 5:54 p.m. In and 2:13 p.m.			ensure the alleged deficient practice do not recur. The Director of Nursing or designee will complete an audit of the EMAR, physicians orders and 24 hour report to review if prn psychoactive medication administered and documentation supports nonpharmacological interventions were attempted prior to administration of the prn psychoactive medication weekly x weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvem process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	e e e 4			
	Review of the nurse's notes for the above dates and times documented, the medication was given for "increased agitation/anxiety" or it was blank as to why it was administered to Resident #144 and failed to reveal any documented non pharmacological interventions attempted prior to administering the antianxiety medication to Resident #144 on the dates and time above. The comprehensive care plan dated, 12/30/2020 documented in part, "Focus: At risk for adverse effects related to use of anti-depressant medication, use of antipsychotic medication and use of anti-anxiety medication." The "Interventions" documented in part, "Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic								

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SUR COMPLETE	
		495227	B. WING _			01/16/2	2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) MPLETION DATE
F 842	Continued From page	e 141	F 8	342			
	related to a dosage of and follow-up as need signs of adverse readmental status, declined ability, lethargy, complete." An interview was compractical nurse) #7 or LPN #7 was documed the Ativan to Resider Ativan is given, LPN very high anxiety and constantly. When ask non-medication intervantianxiety medication bring her to the nurse things, but it doesn't the interventions atteen.	ng) ability or mood/behavior thange. Psychiatrist consult ded. Report to physician ction such as decline in e in positioning/ambulation plaints of dizziness, tremors, aducted with LPN (licensed in 1/16/2020 at 8:45 a.m. inted as having administered at #144. When asked why the #7 stated the resident has					
	nurse) #6; the quality 1/16/2020 at 9:00 a.r staff would administe stated it should be gi non-pharmacological When asked where s non-pharmacological it should be documer	interventions don't work. taff document if they tried interventions, RN #6 stated					
	complete record of a tool for communication	e process of preparing a patient's care and is a vital on among health care team t information as soon as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			01/16/2020
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	possible to ensure the and to reflect ongoing documentation increased omissions, errors and lapse." (4) Administrative staff madministrator and AS were made aware of 1/16/2020 at 1:05 p.m. No further information References: (1) This information we following website:	e accuracy of the information g care. Delayed ases the potential for d inaccuracy due to memory member (ASM) #1, the M #3, the corporate nurse, the above concern on n.	F8	42		